S. HRG. 107–700

DEPARTMENT OF VETERANS' AFFAIRS FOURTH MISSION: CARING FOR VETERANS, SERVICE MEMBERS, AND THE PUBLIC FOLLOWING CONFLICTS AND CRISES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

OCTOBER 16, 2001

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OCTOBER 16, 2001

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WITNESSES

DEPARTMENT OF VETERANS' AFFAIRS FOURTH MISSION: CARING FOR VETERANS, SERVICE MEMBERS, AND THE PUBLIC FOLLOWING CONFLICTS AND CRISES

TUESDAY, OCTOBER 16, 2001

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 2:46 p.m., in room 418, Russell Senate Office Building, Hon. John D. Rockefeller IV (chairman of the committee) presiding.

Present: Senators Rockefeller, Jeffords, Wellstone, Miller, Nelson, and Specter.

Chairman ROCKEFELLER. My apologies to my colleagues and to all. Particularly, I think some of you—Tony, I do not know if you are one of them, but some of you have White House appointments so that you are time constrained and so I am even more embarrassed than usual.

I want to make this opening statement. Obviously, the world has desperately changed. When we gathered last in this hearing room, it was to discuss legislation that would help VA fill its hospitals with qualified nurses, and that was and is a terribly important subject. Other things have overtaken it. The question now really is what happens with the VA if there is a large national catastrophe, domestically as well as with deployed National Guard and troops, and the military cannot take care of everything.

I do not think anybody would make any mistake that caring for the men and women who serve this Nation remains VA's primary responsibility to our veterans. However, VA may be called upon to play a much larger role. We must be sure that VA has the support it needs to fulfill its duties toward military personnel and civilians, should conflicts and crises arise, without sacrificing the veterans part.

VA shares the Federal responsibility for preserving public health during domestic crises. As a partner in the National Disaster Medical System, VA coordinates medical resources and shares staff and supplies with local health providers during public health emergencies. VA also works with other Federal agencies and the Red Cross, as well, as part of the Federal Response Plan to disasters. And, if necessary, they would offer direct patient care to assist communities overwhelmed by large numbers of patients. FEMA coordinates this plan, and the Secretary of Health and Human Services directs the public health care responses.

In the past few weeks, I have heard a great deal about the problems that arise when multiple Federal, State, and local agencies work together—what happens when they do that and respond to disasters. I saw one example of this in my own State of West Virginia following this year's devastating floods. Local health care givers found themselves scrambling for medicines and supplies for West Virginians. The VA had at least one mobile health clinic ready to travel to the area and other clinics would have been available had the State officially requested them.

As you may know, when the VA goes in without an official request, they can treat only veterans; hence, a problem. Due to the lack of information and communication between the VA and State agencies, that official request never came. I am not blaming anybody. It just never happened. The Beckley VA Medical Center staff took one of their own vans, staffed it with their own people on their own time, did a wonderful job providing care to veterans who were afflicted by floods in these destroyed communities.

As Congress focuses on preventing and preparing for terrorism, we have heard again and again that we must include the medical community when we plan for emergencies. As the largest health care system in the Nation, the VA can offer invaluable services during a public health care emergency. This is a huge system with a lot of capacity and the VA has an enormous responsibility walking into times in which we know not what will happen. That may be terrorism, that may be a natural disaster, but we are certainly faced with the possibility of those right now.

By no means am I asking the VA to serve as the first line of defense against terrorism. Secretary Principi, you know that. Other agencies have resources to address these needs and we must not force new missions upon a VA medical system which is already strained to the limit and is being underfunded for the 20th consecutive year.

However, since managed care—not one of my favorite subjects—has eroded the national capacity to deal with large numbers of patients and VA has proved itself capable of preparing for and responding to emergencies, I am resolved that VA's existing resources should be used as efficiently as possible.

In 1982, Congress created VA's so-called fourth mission: serving as the primary medical backup to the Department of Defense during times of conflict. The events of the past week remind us that we must protect VA's capacity for this mission, especially in light of the rapidly shrinking military health care system. I look forward to hearing about what is needed to preserve VA's ability to accept military casualties as well as the question beyond that of civilian casualties and National Guard casualties, should that happen.

Interestingly—and Senator Jeffords and Senator Miller and Senator Wellstone may be interested in this—in 1998, we passed here something called the Veterans' Program Enhancement Act, which is one of those typically marvelous titles that we give to things. This Act directed VA to contract with the National Academy of Sciences to plan for a national center to understand, to prevent, and to treat illnesses related to biological, chemical, and other battlefield exposures. The National Academy of Sciences recommended that the VA and the Department of Defense and HHS work to-

gether to create an interagency National Center for Military Health and Deployment Readiness, guided by a board representing the three Federal agencies and the independent research and veterans' communities.

However, nothing has happened. Nothing has happened. The bill was passed in 1998 and progress seems to rely primarily upon VA and DoD programs. The governing board has never convened. It has never been convened, and I just want to say that I am curious about that. We cannot know whether that could have been helpful, but I am not prepared to say that it could not have been.

I will end up by saying, in brief, that accurate recordkeeping—as we learned during the Gulf War, when it was not done in spite of claims that it was—is essential if VA is to provide appropriate medical care to returning troops and veterans, conduct research, and all the rest of it.

[The prepared statement of Senator Rockefeller follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Good afternoon. I do not have to tell you that we meet today in a world desperately changed. When the Committee last gathered in this hearing room, it was to discuss legislation that would help VA fill its hospitals with qualified nurses, improve educational benefits, assist homeless veterans, and ensure that the rising cost of living does not erode veterans' benefits, among many other important issues. Since then, the tragic events of September 11 have absorbed the Nation and Congress, as we confront fear and loss and forge a new resolve.

Make no mistake—caring for the men and women who served this Nation remains VA's primary mission. However, in light of recent events, VA may be called upon to play a larger role. We must be sure that VA has the support it needs to fulfill its duties toward military personnel and civilians during conflicts and crises, without sacrificing its obligation to provide health care and benefits for veterans.

VA shares the Federal responsibility for preserving public health during domestic crises. As a partner in the National Disaster Medical System, VA coordinates medical resources and shares staff and supplies with local health care providers during public health emergencies. VA also works with other Federal agencies and the Red Cross as part of the Federal Response Plan to disasters, supplying personnel, supplies, facilities, and—if necessary—direct patient care to assist communities overwhelmed by large numbers of patients. FEMA coordinates this plan, and the Secretary of Health and Human Services directs the public health care responses.

In the past few weeks, I have heard a great deal about the problems that arise when multiple Federal, State, and local agencies work together to plan for, and respond to, disasters. I saw one example of this in my own state of West Virginia, following this year's devastating floods. Local health care givers found themselves scrambling for medicines and supplies for West Virginians. VA had at least one mobile health clinic ready to travel to the area, and other clinics would have been available had the state "officially" requested them. As you may know, when VA goes in without an official request, they can treat only veterans. Due to a lack of information and communication between VA and state agencies, that official request never came. The Beckley VA Medical Center staff took out one of their own vans, staffed with their own staff, and did a wonderful job of providing care to veterans in the destroyed communities the only care VA was allowed to offer.

As Congress focuses on preventing and preparing for terrorism, we have heard again and again that we must include the medical community when we plan for emergencies. As the largest health care system in the Nation, VA can offer invaluable services during a public health care emergency, whether that emergency is terrorism or a natural disaster.

By no means am I asking VA to serve as the first line of defense against terrorism. Other agencies have resources to address these needs, and we must not force new missions upon a VA medical system already struggling with limited resources. However, since managed care has eroded the national capacity to deal with large numbers of patients, and VA has proved itself capable of preparing for and responding to emergencies, I am resolved that VA's existing resources should be used as efficiently as possible.

In 1982, Congress created VA's Fourth Mission: serving as the primary medical back up to the Department of Defense during times of conflict. The events of the past weeks remind us that we must protect VA's capacity for this mission, especially in light of the rapidly shrinking military health care system. I look forward to hearing about what is needed to preserve VA's ability to accept military casualties while continuing to care for veterans, especially if the many reservists who work within VA should be called up.

If VA is to perform this Fourth Mission of caring for active duty military casualties during a conflict—and its primary mission of caring for veterans—we must not ignore the lessons learned so painfully in the wake of the Gulf War. All of our efforts to link battlefield exposures to the symptoms reported by returning troops have been compromised by poor medical surveillance and incomplete records.

Accurate record keeping is essential if VA is to provide appropriate medical care to returning troops and veterans, conduct research, and identify health conditions that are likely to be connected to military service. As our Nation prepares for war, the American people deserve assurances that the service branches have corrected previous shortcomings in military public health, not only to assist returning servicemembers in seeking health care and benefits, but to preserve the readiness and trust of our forces. I have asked GAO to prepare testimony on challenges faced by the Department of Defense in establishing a medical surveillance system, and I ask that this testimony be entered into the record.

I look forward to hearing about the best ways to encourage this interagency coordination and communication to shape a seamless medical response to emergencies. I welcome all of the witnesses.

Chairman ROCKEFELLER. I have asked the GAO to prepare testimony on challenges faced by the Department of Defense in establishing a medical surveillance system and I hereby put that in the record.

[The information referred to follows:]

PREPARED STATEMENT OF STEPHEN P. BACKHUS, DIRECTOR, HEALTH CARE-VETERANS' AND MILITARY HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE

VA AND DEFENSE HEALTH CARE

PROGRESS AND CHALLENGES DOD FACES IN EXECUTING A MILITARY MEDICAL SURVEILLANCE SYSTEM

Mr. Chairman and Members of the Committee:

We are pleased to submit this statement for the record on the Department of Defense's (DOD) efforts to establish a medical surveillance system that enables DOD—along with the Department of Veterans Affairs (VA)—to respond to the health care needs of our military personnel and veterans. A medical surveillance system involves the ongoing collection and analysis of uniform information on deployments, environmental health threats, disease monitoring, medical assessments, and medical encounters. It is also important that this information be disseminated in a timely manner to military commanders, medical personnel, and others. DOD is responsible for developing and executing this system and needs this information to help ensure the deployment of healthy forces and the continued fitness of those forces. VA also needs this information to fulfill its missions of providing health care to veterans, backing up DOD in contingencies, and adjudicating veterans' claims for service-connected disabilities. Scientists at VA, DOD, and other organizations also use this information to conduct epidemiological studies and research.[1]

Given our current military actions responding to the events of September 11, you asked us to describe the challenges DOD faces in establishing a reliable medical surveillance system, based on what has been reported about DOD's medical surveillance activities during the Gulf War and Operation Joint Endeavor.[2] This statement focuses on reports GAO,[3] the Institute of Medicine (IOM), the Presidential Advisory

[1] Epidemiology is the scientific study of the incidence, distribution, and control of disease in a population.

[2] United States and allied nations deployed peacekeeping forces to Bosnia beginning in December 1995 in support of Operation Joint Endeavor, the NATO-led Bosnian peacekeeping force.

[3] See list of related GAO products at the end of this statement.

Committee on Gulf War Veterans' Illnesses,[4] and others have issued over the past several years. This statement is also based on interviews we held over the past 2 weeks with various Defense Health Program officials, including officials from the Army Surgeon General's Office.[5]

In summary, GAO, the Institute of Medicine, and others have reported extensively on weaknesses in DOD's medical surveillance capability and performance during the Gulf War and Operation Joint Endeavor and the challenges DOD faces in implementing a reliable medical surveillance system. Investigations into the unexplained illnesses of Gulf War veterans uncovered many deficiencies in DOD's ability to collect, maintain, and transfer accurate data describing the movement of troops, potential exposures to health risks, and medical incidents during deployment. DOD improved its medical surveillance system under Operation Joint Endeavor, which provided useful information to military commanders and medical personnel. However, we and others reported a number of problems with this system. For example, information related to service members' health and deployment status—data critical to an effective medical surveillance system—was incomplete or inaccurate. DOD's numerous databases, including those that capture health information, are currently not linked, which further challenges the department's efforts to establish a single, comprehensive electronic system to document, archive, and access medical surveillance data.

DOD has several initiatives under way to improve the reliability of deployment information and to enhance its information technology capabilities, as we and others have recommended, though some initiatives are several years away from full implementation. Nonetheless, these efforts reflect a commitment by DOD to establish a comprehensive medical surveillance system. The ability of VA to fulfill its role in serving veterans and providing backup to DOD in times of war will be enhanced as DOD increases its medical surveillance capability.

BACKGROUND

An effective military medical surveillance system needs to collect reliable information on (1) the health care provided to service members before, during, and after deployment; (2) where and when service members were deployed; (3) environmental and occupational health threats or exposures during deployment (in theater) and appropriate protective and counter measures; and (4) baseline health status and subsequent health changes.

This information is needed to monitor the overall health condition of deployed troops, inform them of potential health risks, as well as maintain and improve the health of service members and veterans.

In times of conflict, a military medical surveillance system is particularly critical to ensure the deployment of a fit and healthy force and to prevent disease and injuries from degrading force capabilities. DOD needs reliable medical surveillance data to determine who is fit for deployment; to prepare service members for deployment, including providing vaccinations to protect against possible exposure to environmental and biological threats; and to treat physical and psychological conditions that resulted from deployment. DOD also uses this information to develop educational measures for service members and medical personnel to ensure that service members receive appropriate care.

Reliable medical surveillance information is also critical for VA to carry out its missions. In addition to VA's better known missions—to provide health care and benefits to veterans and medical research and education—VA has a fourth mission: to provide medical backup to DOD in times of war and civilian health care backup in the event of disasters producing mass casualties. As such, VA needs reliable medical surveillance data from DOD to treat casualties of military conflicts, provide health care to veterans who have left active duty, assist in conducting research should troops be exposed to environmental or occupational hazards, and identify service-connected disabilities and adjudicate veterans' disability claims.

MEDICAL RECORDKEEPING AND SURVEILLANCE DURING THE GULF WAR WAS LACKING

Investigations into the unexplained illnesses of service members and veterans who had been deployed to the Gulf uncovered the need for DOD to implement an effective medical surveillance system to obtain comprehensive medical data on de-

[4] The President established this committee in May 1995 to conduct independent, open, and comprehensive examinations of health care concerns related to Gulf War service. The committee consisted of physicians, scientists, and Gulf War veterans.

[5] The Secretary of the Army is responsible for medical surveillance for POD deployments, consistent with DOD's medical surveillance policy.

ployed service members, including Reservists and National Guardsmen. Epidemiological and health outcome studies to determine the causes of these illnesses have been hampered due to incomplete baseline health data on Gulf War veterans, their potential exposure to environmental health hazards, and specific health data on care provided before, during, and after deployment. The Presidential Advisory Committee on Gulf War Veterans' Illnesses' and IOM's 1996 investigations into the causes of illnesses experienced by Gulf War veterans confirmed the need for more effective medical surveillance capabilities.[6]

The National Science and Technology Council, as tasked by the Presidential Advisory Committee, also assessed the medical surveillance system for deployed service members. In 1998, the council reported that inaccurate recordkeeping made it extremely difficult to get a clear picture of what risk factors might be responsible for Gulf War illnesses.[7] It also reported that without reliable deployment and health assessment information, it was difficult to ensure that veterans' service-related benefits claims were adjudicated appropriately. The council concluded that the Gulf War exposed many deficiencies in the ability to collect, maintain, and transfer accurate data describing the movement of troops, potential exposures to health risks, and medical incidents in theater. The council reported that the government's recordkeeping capabilities were not designed to track troop and asset movements to the degree needed to determine who might have been exposed to any given environmental or wartime health hazard. The council also reported major deficiencies in health risk communications, including not adequately informing service members of the risks associated with countermeasures such as vaccines. Without this information, service members may not recognize potential side effects of these countermeasures and promptly take precautionary actions, including seeking medical care.

MEDICAL SURVEILLANCE UNDER OPERATION JOINT ENDEAVOR IMPROVED BUT WAS NOT COMPREHENSIVE

In response to these reports, DOD strengthened its medical surveillance system under Operation Joint Endeavor when service members were deployed to Bosnia-Herzegovina, Croatia, and Hungary. In addition to implementing departmentwide medical surveillance policies, DOD developed specific medical surveillance programs to improve monitoring and tracking environmental, and biomedical threats in theater. While these efforts represented important steps, a number of deficiencies remained.

On the positive side, the Assistant Secretary of Defense (Health Affairs) issued a health surveillance policy for troops deploying to Bosnia.[8] This guidance stressed the need to (1) identify health threats in theater, (2) routinely and uniformly collect and analyze information relevant to troop health, and (3) disseminate this information in a timely manner. DOD required medical units to develop weekly reports on the incidence rates of major categories of diseases and injuries during all deployments. Data from these reports showed theaterwide illness and injury trends so that preventive measures could be identified and forwarded to the theater medical command regarding abnormal trends or actions that should be taken.

DOD also established the U.S. Army Center for Health Promotion and Preventive Medicine—a major enhancement to DOD's ability to perform environmental monitoring and tracking. For example, the center operates and maintains a repository of service members' serum samples for medical surveillance and a system to integrate, analyze, and report data from multiple sources relevant to the health and readiness of military personnel. This capability was augmented with the establishment of the 520th Theater Army Medical Laboratory—a deployable public health laboratory for providing environmental sampling and analysis in theater. The sampling results can be used to identify specific preventive measures and safeguards to be taken to protect troops from harmful exposures and to develop procedures to treat anyone exposed to health hazards. During Operation Joint Endeavor, this laboratory was used in Tuzla, Bosnia, where most of the U.S. forces were located, to conduct air, water, soil, and other environmental monitoring.

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[6] *Health Consequences of Service During the Persian Gulf War Recommendations for Research and Information Systems,* Institute of Medicine, Medical Follow-up Agency (Washington, D.C.: National Academy Press, 1996); Presidential Advisory Committee on Gulf War Veterans' Illnesses. Interim Report (Washington, D.C.: U.S. Government Printing Office, Feb. 1996); Presidential Advisory Committee on Gulf War Veterans' Illnesses: Final Report (Washington, D.C.: U.S. Government Printing Office, Dec. 1996).

[7] *National Science and Technology Council Presidential Review Directive 5* (Washington, D.C.: Executive Office of the President, Office of Science and Technology Policy, Aug. 1998).

[8] Health Affairs Policy 96–019 (DOD Assistant Secretary of Defense Memorandum, Jan. 4, 1996).

Despite the department's progress, we and others have reported on DOD's implementation difficulties during Operation Joint Endeavor and the shortcomings in DOD's ability to maintain reliable health information on service members. Knowledge of who is deployed and their whereabouts is critical for identifying individuals who may have been exposed to health hazards while deployed. However, in May 1997, we reported that the inaccurate information on who was deployed and where and when they were deployed—a problem during the Gulf War—continued to be a concern during Operation Joint Endeavor.[9] For example, we found that the Defense Manpower Data Center (DMDC) database—where military services are required to report deployment information—did not include records for at least 200 Navy service members who were deployed. Conversely, the DMDC database included Air Force personnel who were never actually deployed. In addition, we reported that DOD had not developed a system for tracking the movement of service members within theater. IOM also reported that the location of service members during the deployments were still not systematically documented or archived for future use.[10]

We also reported in May 1997 that for the more than 600 Army personnel whose medical records we reviewed, DOD's centralized database for postdeployment medical assessments did not capture 12 percent of those assessments conducted in theater and 52 percent of those conducted after returning home.[11] These data are needed by epidemiologists and other researchers to assess at an aggregate level the changes that have occurred between service members' pre- and postdeployment health assessments. Further, many service members' medical records did not include complete information on in—theater postdeployment medical assessments that had been conducted. The Army's European Surgeon General attributed missing in-theater health information to DOD's policy of having service members hand carry paper assessment forms from the theater to their home units, where their permanent medical records were maintained. The assessments were frequently lost en route.

We have also reported that not all medical encounters in theater were being recorded in individual records. Our 1997 report identified that this problem was particularly common for immunizations given in theater. Detailed data on service members' vaccine history are vital for scheduling the regimen of vaccinations and boosters and for tracking individuals who received vaccinations from a specific lot in the event health concerns about the vaccine lot emerge. We found that almost one-fourth of the service members' medical records that we reviewed did not document the fact that they had received a vaccine for tick-borne encephalitis. In addition, in its 2000 report, IOM cited limited progress in medical recordkeeping for deployed active duty and reserve forces and emphasized the need for records of immunizations to be included in individual medical records.

CURRENT POLICIES AND PROGRAMS NOT FULLY IMPLEMENTED

Responding to our and others' recommendations to improve information on service members' deployments, in-theater medical encounters, and immunizations, DOD has continued to revise and expand its policies relating to medical surveillance, and the system continues to evolve. In addition, in 2000, DOD released its Force Health Protection plan, which presents its vision for protecting deployed forces.[12] This vision emphasizes force fitness and health preparedness and improving the monitoring and surveillance of health threats in military operations. However, IOM criticized DOD's progress in implementing its medical surveillance program and the failure to implement several recommendations that IOM had made. In addition, IOM raised concerns about DOD's ability to achieve the vision outlined in the Force Health Protection plan. We have also reported that some of DOD's programs designed to improve medical surveillance have not been fully implemented.

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[9] *Defense Health Care: Medical Surveillance Improved Since Gulf War, but Mixed Results in Bosnia* (GAO/NSIAD–97–136, May 13, 1997).

[10] See *Institute of Medicine, Protecting Those Who Serve. Strategies to Protect the Health of Deployed U.S. Forces* (Washington, D.C., National Academy Press, 2000).

[11] In many cases, we found that these assessments were not conducted in a timely manner or were not conducted at all. For example, of the 618 personnel whose records we reviewed, 24 percent did not receive in-theater postdeployment medical assessments and 21 percent did not receive home station postdeployment medical assessments. Of those who did receive home station postdeployment medical assessments, the assessments were on average conducted nearly 100 days after they left theater—instead of within 30 days, as DOD requires.

[12] Joint Staff, Medical Readiness Division, Force Health Protection (2000).

RECENT IOM REPORT CONCLUDES SLOW PROGRESS BY DOD IN IMPLEMENTING RECOMMENDATIONS

IOM's 2000 report presented the results of its assessment of DOD's progress in implementing recommendations for improving medical surveillance made by IOM and several others. IOM stated that, although DOD generally concurred with the findings of these groups, DOD had made few concrete changes at the field level. For example, medical encounters in theater were still not always recorded in individuals' medical records, and the locations of service members during deployments were still not systematically documented or archived for future use. In addition, environmental and medical hazards were not yet well integrated in the information provided to commanders.

The IOM report notes that a major reason for this lack of progress is no single authority within DOD has been assigned responsibility for the implementation of the recommendations and plans. IOM said that because of the complexity of the tasks involved and the overlapping areas of responsibility involved, the single authority must rest with the Secretary of Defense.

In its report, IOM describes six strategies that in its view demand further emphasis and require greater efforts by DOD:

- Use a systematic process to prospectively evaluate non-battle-related risks associated with the activities and settings of deployments.
- Collect and manage environmental data and personnel location, biological samples, and activity data to facilitate analysis of deployment exposures and to support clinical care and public health activities.
- Develop the risk assessment, risk management, and risk communications skills of military leaders at all levels.
- Accelerate implementation of a health surveillance system that completely spans an individual's time in service.
- Implement strategies to address medically unexplained symptoms in populations that have deployed.
- Implement a joint computerized patient record and other automated record-keeping that meets the information needs of those involved with individual care and military public health.

OUR WORK ALSO INDICATES SOME DOD PROGRAMS FOR IMPROVING MEDICAL SURVEILLANCE ARE NOT FULLY IMPLEMENTED

DOD guidance established requirements for recording and tracking vaccinations and automating medical records for archiving and recalling medical encounters. While our work indicates that DOD has made some progress in improving its immunization information, the department faces numerous challenges in implementing an automated medical record.

In October 1999, we reported that DOD's Vaccine Adverse Event Reporting System, which relies on medical personnel or service members to provide needed vaccine data, may not have included information on adverse reactions because DOD did not adequately inform personnel on how to provide this information.[13]

Additionally, in April 2000, we testified that vaccination data were not consistently recorded in paper records and in a central database, as DOD requires.[14] For example, when comparing records from the database with paper records at four military installations, we found that information on the number of vaccinations given to service members, the dates of the vaccinations, and the vaccine lot numbers were inconsistent at all four installations. At one installation, the database and records did not agree 78 to 92 percent of the time. DOD has begun to make progress in implementing our recommendations, including ensuring timely and accurate data in its immunization tracking system.

The Gulf War revealed the need to have information technology play a bigger role in medical surveillance to ensure that the information is readily accessible to DOD and VA. In August 1997, DOD established requirements that called for the use of innovative technology, such as an automated medical record device for documenting inpatient and outpatient encounters in all settings and that can archive the information for local recall and format it for an injury, illness, and exposure surveillance database.[15] Also, in 1997, the President, responding to deficiencies in DOD's and VA's data capabilities for handling service members' health information, called for

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[13] *Medical Readiness: DOD Faces Challenges in Implementing Its Anthrax Vaccine Immunization Program* (GAO/NSIAD–00–36, Oct. 22, 1999).

[14] *Medical Readiness: DOD Continues to Face Challenges in Implementing Its Anthrax Vaccine Immunization Program (GAO/T–NSIAD–00–157, Apr. 13, 2000).*

[15] DOD Directive 6490.2, "Joint Medical Surveillance" (Aug. 30, 1997).

the two agencies to start developing a comprehensive, lifelong medical record for each service member. As we reported in April 2001, DOD's and VA's numerous databases and electronic systems for capturing mission-critical data, including health information, are not linked and information cannot be readily shared.[16]

DOD has several initiatives under way to link many of its information systems—some with VA. For example, in an effort to create a comprehensive, lifelong medical record for service members and veterans and to allow health care professionals to share clinical information, DOD and VA, along with the Indian Health Service (IHS),[17] initiated the Government Computer-Based Patient Record (GCPR) project in 1998. GCPR is seen as yielding a number of potential benefits, including improved research and quality of care, and clinical and administrative efficiencies. However, our April 2001 report describes several factors—including planning weaknesses, competing priorities, and inadequate accountability—that made it unlikely that DOD and VA would accomplish GCPR or realize its benefits in the near future. To strengthen the management and oversight of GCPR, we made several recommendations, including designating a lead entity with a clear line of authority for the project and creating comprehensive and coordinated plans for sharing meaningful, accurate, and secure patient health data.

For the near term, DOD and VA have decided to reconsider their approach to GCPR and focus on allowing VA to view DOD health data. However, under the interim effort, physicians at military medical facilities will not be able to view health information from other facilities or from VA—now a potentially critical information source given VA's fourth mission to provide medical backup to the military health system in times of national emergency and war.

Recent meetings with officials from the Defense Health Program and the Army Surgeon General's Office indicate that the department is working on issues we have reported on in the past, including the need to improve the reliability of deployment information and the need to integrate disparate health information systems. Specifically, these officials informed us that DOD is in the process of developing a more accurate roster of deployed service members and enhancing its information technology capabilities. For example, DOD's Theater Medical Information Program (TMIP) is intended to capture medical information on deployed personnel and link it with medical information captured in the department's new medical information system, now being field tested.[18] Developmental testing for TMIP is about to begin and field testing is expected to begin next spring, with deployment expected in 2003. A component system of TMIP—Transportation Command Regulating and Command and Control Evacuation System—is also under development and aims to allow casualty tracking and provide in-transit visibility of casualties during wartime and peacetime. Also under development is the Global Expeditionary Medical System, which DOD characterizes as a stepping stone to an integrated biohazard surveillance and detection system.

CONCLUDING OBSERVATIONS

Clearly, the need for comprehensive health information on service members and veterans is very great, and much more needs to be done. However, it is also a very difficult task because of uncertainties about what conditions may exist in a deployed setting, such as potential military conflicts, environmental hazards, and frequency of troop movements. While progress is being made, DOD will need to continue to make a concerted effort to resolve the remaining deficiencies in its surveillance system. Until such a time that some of the deficiencies are overcome, VA's ability to perform its missions will be affected.

CONTACT AND ACKNOWLEDGMENTS

For further information, please contact Stephen P. Backhus. Individuals making key contributions to this testimony included Ann Calvaresi Barr, Karen Sloan, and Keith Steck.

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[16] Computer-Based Patient Records: Better Planning and Oversight by VA, DOD, and IHS Would Enhance Health Data Sharing (GAO–01–459, Apr. 30, 2001).

[17] IHS was included in the effort because of its population-based research expertise and its long-standing relationship with VA.

[18] Composite Health Care System H (CHCS II) is expected to capture information on immunizations; allergies; outpatient encounters, such as diagnostic and treatment codes; patient hospital admission and discharge; patient medications; laboratory results; and radiology. CHCS II is expected to support best business practices, medical surveillance, and clinical research.

RELATED GAO PRODUCTS

Computer-Based Patient Records. Better Planning and Oversight by VA, DOD, and IHS Would Enhance Health Data Sharing (GAO–01459, Apr. 30, 2001).

Medical Readiness: DOD Continues to Face Challenges in Implementing Its Anthrax Vaccine Immununization Program (GAO/T–NSIAD–00–157, Apr. 13, 2000).

Medical Readiness: DOD Faces Challenges in Implementing Its Anthrax Vaccine Immunization Program (GAO/NSIAD–00–36, Oct. 22, 1999).

Chemical and Biological Defense: Observations on DOD's Plans to Protect U.S. Forces (GAO/T–NSIAD–98–83, Mar. 17, 1998).

Gulf War Veterans. Incidence of Turnors Cannot Be Reliably Determined From Available Data (GAO/NSIAD–98–89, Mar. 3, 1998).

Gulf War Illnesses: Federal Research Strategy Needs Reexamination (GAO–T–NSIAD–98–104, Feb. 24, 1998).

Gulf War Illnesses: Research, Clinical Monitoring and Medical Surveillance (GAO/T–NSIAD–98–88, Feb. 5, 1998).

Defense Health Care: Medical Surveillance Improved Since Gulf War, but Mixed Results in Bosnia (GAO/NSIAD–97–136, May 13, 1997).

Chairman ROCKEFELLER. I welcome everybody. Secretary Principi, there may be several other Senators who wish to make a statement. I would welcome their doing so if they want to, and again apologize for my own inexcusable lateness.

Senator Jeffords?

Senator JEFFORDS. Thank you. I want to commend you on the tremendous work you did on September 11 and the beds that were provided. It was just amazing, an excellent job.

I am anxious to hear your remarks, but let me again first say that in New England, we are really proud of your work on VISN 1 and throughout the White River Junction VA in particular. But I believe we owe it to those dedicated professionals on the front lines to clarify a few things for them.

First of all, we need to allay their fears that the resources will be there to cover these expenditures, and just being prepared costs money.

Second, I believe guidance is needed on how to balance these competing demands in the event of an emergency, and we also need to make sure that we are not double-counting the same beds for different purposes.

And finally, I hear concern that while both the VA and the municipalities are well prepared for traditional types of disaster, there is much that needs to be done to properly respond to an emergency involving hazardous materials and biological, et cetera, and I am concerned there is insufficient training and equipment in this area.

So once again, I appreciate what you are doing and hope you can give us some reassurance in some of these areas. Thank you very much.

Chairman ROCKEFELLER. Senator Miller?

Senator MILLER. I have a statement, but I would like to ask that it be made part of the record and I will just skip giving it.

Chairman ROCKEFELLER. Thank you, Senator.

[The prepared statement of Senator Miller follows:]

PREPARED STATEMENT OF HON. ZELL MILLER, U.S. SENATOR FROM GEORGIA

Thank you Mr. Chairman, and I commend you for convening a hearing to examine this very important subject. The events of September 11th, coupled with the continuing threat of terrorist attacks, demand that we be prepared for the possibility of mass casualties that require immediate medical attention. As we know, such casualties could be military, civilian, or both. For the VA to be an effective assisting agency in these large-scale emergencies, we must ensure that interagency and inter-

governmental coordination is thoroughly planned beforehand. I know that this coordination already exists on some level, and we must determine if it is sufficient to handle thousands, rather than hundreds of patients. To that end, Secretary Principi has formed a senior level working group to assess the VA's ability in managing a multi-scenario crisis, and I look forward to seeing those results.

It is imperative that this complete and honest assessment of the VA's ability to assist with such national emergencies is done with the primary mission of quality service to veterans in mind. If more resources are needed in the areas of facilities, equipment, or manpower, we need to identify those deficiencies and act on them before a disaster arrives.

We have seen that combating terrorism and safeguarding our citizens is an expensive endeavor. I anticipate that the VA's responsibility in preserving public health during a domestic crisis will be no exception. In order for the VA to be viable in this "Fourth Mission," we must realistically identify the requirements, fund any deficiencies, implement an expeditious plan of action, and conduct realistic training. We all hope that this kind of contingency preparation will never be needed, but the cost of not being fully prepared could be staggering. Therefore, we must fulfill our obligation of providing emergency healthcare service to veterans, service members, and when necessary, civilians.

I would also like to recognize and thank the distinguished panelists appearing here today for imparting their thoughts and expertise on this most important issue.

Chairman ROCKEFELLER. Senator Wellstone?

Senator WELLSTONE. I would rather go forward with the testimony. My apology to the Secretary. I have a markup I have to go to, Mr. Chairman, so I will just get to hear the beginning and then I will read the full statement. I do want to say to Secretary Principi, I think the veterans' community has a great deal of affection for him and really trusts and believes in him and I thank him for his leadership.

Chairman ROCKEFELLER. Senator Nelson?

Senator NELSON. Thank you, Mr. Chairman. I do not want to extend the timeframe. I am anxious to get to the Secretary's comments, as well, but I would like to begin by thanking you for holding this hearing to address the role and responsibility of the Veterans' Affairs Department in coordinating emergency medical responses. Fortunately, we have never had one in Nebraska. We have never had to call on your agency. But it is reassuring to know that if we did have that need, that it would be there to be responded to.

I would like to thank you for our conversation this morning on an entirely different matter and for being responsive to the needs of our veterans in not only a professional but a caring way. I look forward to your comments today. Thank you.

Chairman ROCKEFELLER. Thank you, Senator Nelson.

Senator Specter has arrived and we would welcome any words from him.

Senator SPECTER. Well, thank you very much, Mr. Chairman. I regret being late. Let me pick up on the flow of action and perhaps have a question or two when I catch up a little. Good morning, Mr. Secretary.

Chairman ROCKEFELLER. Spoken like a skilled lawyer.

Senator SPECTER. It is better than speaking like an unskilled lawyer. [Laughter.]

Chairman ROCKEFELLER. Or not being one at all. [Laughter.]

Secretary Principi, we are delighted to have you here. Your full statement is a part of the record and we welcome whatever you have to say.

STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS' AFFAIRS, ACCOMPANIED BY FRAN MURPHY, DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS' AFFAIRS

Mr. PRINCIPI. Thank you, Mr. Chairman, Senator Specter, members of the committee. It is always a privilege to appear before you, especially on an issue of such critical importance to all Americans in the aftermath of this crisis.

I am very pleased to be joined by Dr. Fran Murphy, our Deputy Under Secretary of Health, who has a great deal of expertise in emergency preparedness, and I am pleased she is with me, as well as my two colleagues one from HHS and one from the Department of Defense who will be testifying shortly.

I think it is so terribly important, as I indicated yesterday before the House, that we break down the barriers in government and stress the importance of cooperation across all levels of government today to respond to the enormous tragedy that befell America. I will be very, very brief.

I believe that VA has played a very, very important role in emergency management throughout its history, and certainly over the past 20 years, as we look at the natural disasters that have hit America. From Hurricane Hugo, Hurricane Andrew, the Northern California earthquake, the devastating floods in the Midwest, and as you indicated, Mr. Chairman, in West Virginia, and more recently in Houston, VA has been present and responded to legislation that was passed creating the VA–DoD Contingency Hospital System, the National Disaster Medical System, and to various Presidential directives. These have made VA a partner, along with FEMA, HHS, and DoD in responding to crises in America.

Clearly on September 11, I am very, very proud of the way VA people responded in New York at all levels. At our health care system, they were there literally taking people in off the street with their injuries. Our regional office benefits counselors were there at the family assistance center on 94th Street at the pier, assisting families with benefits counseling. Our PTSD counselors from various parts of the country convened in New York to assist, again, not only veterans but families of veterans, fire fighters, and police deal with the trauma of the aftermath of the crisis.

At all levels, our plans and people worked well, in treatment, in sharing our inventory of pharmaceuticals and supplies, in benefits counseling, and in providing for the expeditious memorial services at our national cemetery in New York. I think all of us can be very, very proud of the way our people performed.

But you know, Mr. Chairman and members of the committee, regrettably, 6,000 young men and women, for the most part, died in that tragedy. There were not many survivors, relatively few, unfortunately. Had there been more seriously wounded people, I question—and I only speak for my Department—whether we would have had the capability to respond adequately to treatment of the seriously wounded if there had been thousands, maybe tens of thousands if that strike would have occurred later in the day when there were 50,000 people in the World Trade Center as opposed to maybe 10,000 or 12,000 in the relatively early morning hours of Wall Street. What would have happened in that case? I believe that

collectively we would have been overwhelmed, quite honestly, and I think that is something that we all have to consider in the aftermath of this tragedy.

A mission in statute is our words, in my view. It is kind of like pacing the word "Humvee" on the side of a Chevrolet and trying to believe that it would be a mountain terrain vehicle. It is still a Chevrolet.

So I think that VA does have a fourth mission as a backup and also in cases of emergency to care for civilians, and to do that, we need to be prepared. We need to be fully funded, and I am not here asking for money, but I do think that we have a responsibility, all of us in the executive branch of government, to identify what our requirements are, what are reasonable levels of risk and vulnerability that we want to be prepared to deal with, and to ensure that those requirements are well understood. We can, by working with Congress, balance capacity and dollars and make the policy decisions as to what it is going to take to ensure that we have the resources, we have the bed capacity, we have the staffing, we have the training, we have the pharmaceuticals and medical supplies, and we are ready to address matters during an event.

I convened a task force, an emergency preparedness task force, shortly after September 11 to take a look at where we needed to improve. We did identify that we need to improve dealing with multiple scenario crises, with call-up reserve and Guard personnel, with our training, protective equipment. So there are many, many areas that we have to work on.

I am pleased the President has established the Office of Homeland Security so that the principal players in emergency preparedness in responding to crises, be they manmade or natural, weapons of mass destruction, will know what needs to be done and that we can ask Congress for the resources necessary to respond to them. Thank you.

Chairman ROCKEFELLER. Thank you, Secretary Principi.

[The prepared statement of Mr. Principi follows:]

PREPARED STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, I thank you for the opportunity to testify before the committee on VA's preparedness to perform its missions under the conditions of military conflict abroad and terrorist attacks at home. I am accompanied by Dr. Frances Murphy, VA's Deputy Under Secretary for Health.

My testimony will cover four significant areas:

- how VA responded on, and in the days following, September 11;
- VA's emergency response missions;
- the challenges facing VA; and
- the actions we are taking in response to those challenges.

Mr. Chairman, I will take this opportunity to again thank all VA employees for their efforts—whether they have been directly involved or have been a part of local VA and community efforts—in responding to the needs of victims and their families in New York, Washington, and Pennsylvania. I particularly want to commend VA staff in the immediate areas for their efforts to continue serving veterans in very difficult circumstances and beyond this—to support community family and victim assistance efforts in New York, New Jersey, and at the Pentagon.

VA operates the largest integrated national health care system in the country and with our 1200 sites nationwide, provides direct care benefits and memorial services in every state. We expect that this national resource will be called on to provide significant assistance should mass casualty situations arise. We have responded well in this circumstance and are prepared to provide assistance to the Department of Defense should the need arise. We are reexamining our plans and will be taking

steps to strengthen them. We also stand ready to assist Governor Ridge and our other federal partners in the weeks ahead as they strengthen the Nation's ability to prevent and respond to any future terrorist attack.

VA'S RESPONSE TO THE EVENTS OF SEPTEMBER 11

Veterans Health Administration

VA reacted very quickly to the events of September 11, 2001. Immediately following the second aircraft crash into the World Trade Center, the VA Continuity of Operations Plan (COOP) was activated. Alternate sites, which serve as command centers and give VA leadership the ability to manage a crisis in the event VA's headquarters is closed down, were operational and key personnel were deployed within a few hours.

While staff in the Central Office assured the continuity of operations, the Veterans Integrated Service Networks (VISN) 3 and 5 command centers were activated. VISN 4 provided support to the response following the downed aircraft in Pennsylvania. VA staff supported the special security mission during the President's address to the Nation.

In New York, VA was dealing with the greatest national tragedy to touch our shores in a very immediate way, caring for patients, managing emergent situations, heightening security, deploying staff, sharing inventory, assuring continuous communications, all very close to ground zero. It should be noted that in New York nearly every person in the VA family has been affected in some personal way by the tragedy. Some VA staff work so close to where the World Trade Centers stood that they watched the entire catastrophe unfold before their eyes. Some staff had loved ones and close friends in the towers who haven't come home.

While the wounded were few, they were significant, and VA facilities in New York provided much needed supplies to the emergency workers and the National Guard to help them carry out their jobs in the immediate aftermath. VA continues to provide medical support to 3,000 members of the National Guard who are providing security to the city and its critical infrastructure. The Network's centralized kitchen and laundry operations worked miracles in keeping food and clean linens stocked at all of our medical centers in New York and New Jersey, fighting bridge and tunnel closures, rigorous inspection stops and using VA Police escorts to get around town and into the suburbs. Whereas many businesses and hospitals in the city were without telephone communications, our team had telephones continuously up and working.

Since the tragedy, VA outreach teams have been staffing family and victim assistance centers around the city and in New Jersey. We are now gearing up for the emotional and traumatic impact this event is likely to generate in the weeks and months ahead. The mental health team across the network is reaching out to those who are at risk.

As a part of VA's support of civilian emergencies under the Federal Response Plan, two VA critical care burn nurses were deployed to Cornell Medical Center Burn Unit and four critical care burn nurses were deployed to the Washington Hospital Center Burn Unit in Washington, DC to augment their staffs.

On the Saturday following the terrorist attacks, staff from VA's National Center for PTSD arrived in Virginia to assist DoD in its relief efforts at the Pentagon. They provided education for counselors and debriefing and psychoeducational support for relief staff that included Red Cross personnel and DoD Casualty Assistance Officers. Among the tools they created for assisting the relief workers were a Debriefing Facilitators Manual, an evaluation questionnaire for Casualty Assistance Officers, and a computerized self-assessment for the Army Community Support Center staff.

Within days following the event, VA broadcast the Department of Defense-sponsored series on "Medical Management of Biological and Chemical Casualties", throughout the VA system using the VA's Knowledge Satellite Network. In addition, a nationwide satellite videoconference on "Medical Response to Chemical and Biological Agent Exposure" will be broadcast to VA facilities on October 16, 2001, followed by "Medical Response to Radiological Agent Exposure" in November.

Veterans Benefits Administration

The Veterans Benefits Administration (VBA) has had an active role in administering benefits to veterans and their families affected by the events of September 11. The New York Regional Office (NYRO) has been very involved in helping the survivors and family members affected by the World Trade Center disaster, while the Washington Regional Office (WRO) and personnel from VBA Headquarters have been supporting the Department of Defense in providing assistance to family members of the victims of the attack on the Pentagon.

On September 17, VBA established an information, assistance, and on-site processing unit at DoDs Family Assistance Center. The Washington Regional Office, along with VA headquarters staff, are providing the coverage for this unit and VA's Insurance Center in Philadelphia and each of the benefits programs within VBA are supporting them.

The New York Regional Office (NYRO) established a team of employees who are providing help at the New York City Family Assistance Center, located at Pier 94. Vocational Rehabilitation and Employment, Loan Guaranty, and Veterans Benefits and Services Divisions developed alternate plans to provide counseling, to close home loans, and to interview veterans at off-site locations. Telephone calls about benefits issues were rerouted to other Regional Offices until the NYRO toll-free service was restored.

In an effort to ensure control and efficient, effective service to the survivors of this terrible tragedy we issued a letter to each of our field stations outlining procedures for handling all claims related to the attack. All claims processing for this initiative has been centralized to our Compensation and Pension Service at Headquarters.

We have also established a toll-free telephone number for the survivors, families of the victims, and DoD Casualty Assistance Officers to obtain information about benefits and services offered by VA. They are being notified of this special number in a letter that VBA is sending to each of the affected families. In addition, VA's web site offers information on benefits and services available to the survivors.

We have streamlined the claims process as much as possible in an effort to be as supportive as possible of the families at this difficult time. Working with DoD, we have obtained direct online access to the Defense Eligibility and Entitlement Records System (DEERS) to obtain data on dependents allowing us to conduct on-site claims processing. We are faxing claims for Servicemembers Group Life Insurance (SGLI) directly to the Office of SGLI in Newark where the claims are processed within 24 hours. We have also implemented similar procedures for processing burial claims and headstone or marker applications.

I am pleased to say that both DoD and the families have indicated appreciation for the support and services we have been able to offer in this very difficult time.

National Cemetery Administration

The National Cemetery Administration (NCA) was quick to respond to the events of September 11, 2001. After news of the terrorist attacks was received and the alternate site was activated, the NCA Continuity Of Operations (COOP) team was there to participate fully in guaranteeing that VA was able to continue meeting its missions.

As long as the COOP was activated, NCA was an active participant in the One VA effort to guarantee that key functions were carried out. For NCA, this included making decisions concerning burials for victims of the attacks. NCA remained sensitive to the needs of their families during this crisis, making accommodations wherever possible. All VA national cemeteries were directed to treat all VA burials resulting from this tragedy as high priority, and to honor requests for weekend burials and to extend hours, if necessary.

All national cemeteries remained operational with the exception of Ft. Rosecrans and Barrancas National Cemeteries, which, because of the attacks, were temporarily closed for burials. This was a result of the proximity of the cemeteries to military bases with restricted access. This interruption in service lasted only a short time and all burials scheduled before the attacks were successfully rescheduled and completed.

It was reported that there had been cancellations of military funeral honors by the Department of Defense. Cemetery Directors were urged to seek alternate honors approaches, including the use of cemetery representatives and/or other employees or additional Veteran Service Organization assistance if possible.

NCA has provided or scheduled burials for 15 victims in its national cemeteries, with three additional requests having been made but services not yet scheduled. We immediately began providing Presidential Memorial Certificates (PMC) to the families of the active-duty personnel and veterans killed on September 11. PMCs bear the President's signature and commemorate a person's honorable service to the Nation. NCA has begun to provide a headstone or marker for several victims. In those cases where remains are unrecoverable, we will be able to provide a memorial marker in lieu of an actual burial.

NCA will continue to meet the burial needs of the victims of this horrendous act in a compassionate manner.

In short, VA's response to the attacks was swift, orderly, and effective. And that response is consistent with VA's history of being there in times of great need.

THE INTERAGENCY PLANNING PROCESS FOR THE FRP AND NDMS

Mr. Chairman, the Committee asked specifically how VA functions within the federal system under the Federal Response Plan (FRP). The FRP establishes the plan for interagency response to disasters. The FRP organizes interagency response into 12 "Emergency Support Functions" (ESFs). Each ESF is led by a Primary Agency that serves as the Federal executive agent to accomplish the ESF mission. Each ESF also has a number of Support Agencies that provide support to the Primary Agency in order to accomplish the ESF mission. VA is a Support Agency in the following four ESFs: (1) ESF #3, Public Works and Engineering; (2) ESF #6, Mass Care; (3) ESF #7, Resource Support; and (4) ESF #8, Health and Medical Services. VA may receive mission assignments from the Primary Agencies in charge of those four ESFs, most frequently from the Department of Health and Human Services, the Primary Agency for ESF #8. The mission assignments are the mechanisms FEMA uses to task other Federal agencies, with or without reimbursement, to provide services under the FRP. VA employee salaries remain the responsibility of VA (i.e., they are not reimbursed).

The four National Disaster Medical System (NDMS) partner agencies (VA, DoD, FEMA and Public Health Service) review and update plans via monthly meetings of the NDMS Directorate Staff. There is an NDMS Senior Policy Group (SPG), which sets major policy direction. The Under Secretary for Health represents VA at SPG meetings. An annual NDMS Conference is also conducted by the four partner agencies.

How FEMA Engages HHS and VA in Preparing for the Most Efficient Responses to Public Healthcare Emergencies

FEMA uses the FRP structure to engage HHS and VA in providing for health care in emergencies. The FRP includes an Emergency Support Function #8 for Health and Medical Services. As noted above, HHS is the Primary Agency for ESF #8 and VA is a Support Agency. Therefore, VA receives mission assignments from HHS to support health emergencies.

VA works closely with the Federal Emergency Management Agency to ensure continuity of operations.

Gulf War-Related Issues:

Mr. Chairman, you also requested that we address the importance of good record keeping for force protection and for post deployment health care and on the status of development of the National Center for Military Deployment Health Research.

In preparing to care for veterans of future wars, we must of necessity look back to the Gulf War and the lessons learned there. I think that everyone now realizes the impact that poor record keeping during the Gulf War has had on our subsequent efforts to respond to Gulf War veterans' health issues. Both VA and DOD have been hampered by poor records of immunizations given to U.S. service members, inadequate troop location data, limited data on exposures to potential health hazards, and the absence of baseline health data on new military recruits. It is my understanding that the Department of Defense (DOD) has vigorously applied many lessons learned from our experience with the Gulf War. I believe that they are developing a strategy to protect the health of military members from medical and environmental hazards associated with military service to the maximum extent possible. For example, I understand that DOD is actively working on a computer-based record that will enable more accurate assessments of the effectiveness of military health care, will help direct preventive services for military members, and will be useful for other agencies with responsibility for veterans' health such as the VA. Both VA and DOD recognize the need for a continuous assessment of the current and future health of military members through medical surveillance, longitudinal health studies, adequate medical record documentation, and clinical follow-up. In response, DOD has initiated its Millennium Cohort study—a long-term longitudinal study of the health of a representative group of active duty service members. These activities will also serve us well as we face health issues from future veterans from U.S. military missions.

Congress responded to some of the lessons learned in the Gulf War by passing PL 105–368. In response to § 103 of that law, VA requested the Institute of Medicine (IOM) to establish a committee of experts to provide recommendations on establishing a national center or centers for military deployment health research. Their November 1999 report, National Center for Military Deployment Health Research, contained two major recommendations: 1) that VA establish Centers for the Study of War-Related Illnesses, and 2) that there be established a National Center for Military Deployment Health Research (NCMDHR) under the auspices of the Military and Veterans Health Coordinating Board (MVHCB) that would focus on the

health of active, reserve, and guard forces, and veterans and their families. On September 7, 2000, a joint inter-agency operational plan concurring with both recommendations, was signed by the Secretaries of the Departments of Veterans Affairs, Defense, and Health and Human Services, and was transmitted to Congress.

Regarding the first recommendation, on May 8, 2001, I announced the establishment of two new Centers for the Study of War-Related Illnesses (CSWRI) at East Orange, NJ, and Washington, DC VA Medical Centers. These new centers are in part a response to debilitating but often difficult to diagnose health problems of some veterans returning from virtually all military and peacekeeping missions. For the second recommendation, we reported that the NCMDHR concept required broad cooperation from the Departments of Defense, Health and Human Services, and Veterans Affairs, and that this can be best assured through the MVHCB. We also reported our belief that an evolutionary approach towards establishing a new National Center will afford the best opportunity to ensure that we arrive at a structure and function that best meets the needs of our service personnel, veterans, and their families. We therefore proposed that the National Center be composed of the existing Research Working Group (RWG) of the MVHCB, which will serve as the operational arm of this Center. Following the September 2000 joint report, the interagency RWG has adopted IOM's NCMDHR concept by generating regular research reports about existing deployment health research, identifying gaps and duplicative efforts, and making recommendations for correcting deficiencies using both federal and non-federal research capabilities.

VA'S HISTORY OF DISASTER RESPONSE

We are proud of our history of responsiveness to local and national disasters. The list is too long to include all our efforts, but just within the past 12 years, we have compiled a notable record of service in times of crisis. For example:

In 1989, as aftershocks of the October 17 earthquake continued to rock Northern California, VA opened the doors of its San Francisco and Martinez Medical Centers to supplement local emergency medical activities. Employees of the San Francisco VAMC staffed a mobile health-screen clinic that was deployed to area homeless shelters, and VA personnel were on hand at 17 federal disaster centers in the area.

When Hurricane Hugo struck Puerto Rico and the Eastern U.S. in 1989, VA facilities took direct hits, but their preparations enabled them to recover quickly and get to the business of helping their neighbors with services and shelter.

VA was ready in Florida in 1992 after Hurricane Andrew, and we quickly deployed to serve veterans and their communities stunned by that overwhelming disaster.

Even before the waters of the devastating 1993 Midwest floods receded, VA was helping veterans cope with the damage by instituting fast-response, one-day approval and processing of home-loan insurance issues, and delaying payment dates to allow veterans to recover from the disaster. We did this even though our own offices were flooded and many of our employees were working from home.

VA's Emergency Response Mission

The preceding are vivid examples of the manner in which VA responds to emergencies. The primary responsibilities and authorities governing VA's emergency management efforts include:

- *VA and Department of Defense Contingency Hospital System,* Public Law 97–174, May 1982, requires VA to serve as the primary contingency back-up to the Department of Defense medical services.
- *National Disaster Medical System (NDMS)* was established in 1984 by agreement between Department of Defense, Department of Health and Human Services, VA, and Federal Emergency Management Agency. It operates to provide capability for treating large numbers of patients who are injured in a major peacetime disaster within the continental United States, or to treat casualties resulting from a conventional military conflict overseas.
- *Federal Response Plan, (updated 1999)* implemented Public Law 93–288, the Robert T. Stafford Disaster Relief and Assistance Act as amended, and established the architecture for a systematic, coordinated, and effective Federal response to a disaster or emergency situation.
- *Executive Order 12656,* Assignment of Emergency Preparedness Responsibilities, November 1988, charged VA to plan for emergency health care services for VA beneficiaries in VA medical facilities, active duty personnel, and, as resources permit, to civilians in communities affected by national security emergencies and for mortuary services for eligible veterans and to advise on methods for interment of the dead during national security emergencies.

• *Federal Radiological Emergency Response Plan* (FRERP) (May 1, 1996) established and organized an integrated capability for coordinated response by Federal agencies to peacetime radiological emergencies. VA's Medical Emergency Radiological Response Team (MERRT) is a federal resource available to respond to radiological emergencies.

• *Presidential Decision Directive—62,* Combating Terrorism, May 1998, tasked U.S. Public Health Service (USPHS), working with VA, to ensure that adequate stockpiles of antidotes and other necessary pharmaceuticals are maintained nationwide and to train medical personnel in NDMS hospitals.

• *Presidential Decision Directive—63,* Critical Infrastructure Protection (May 22, 1998) tasks VA to develop and implement plans to protect its infrastructure, including facilities, information systems, telecommunications systems, equipment and the organizations necessary to accomplish our mission to provide benefits and services to veterans.

• *Presidential Decision Directive—67,* Continuity of Operations (October 21, 1998) tasks all Federal Departments and Agencies, including VA to ensure that their critical functions and operations continue under all circumstances and a wide range of possible threats.

VA works closely with the Federal Emergency Management Agency to ensure compliance with the Continuity of Government and Continuity of Operations requirements in Presidential Decision Directive 67, titled Enduring Constitutional Government and Continuity of Government Operations.

VA also supports the Department of Health and Human Services in its mission of providing health and medical response following disasters, including terrorist incidents. In this regard, VA has significant medical assets that could assist the Nation should mass casualties occur. VA operates the Nation's largest integrated health care system; treating almost four million patients per year in hospitals and clinics in every state and Puerto Rico; and employing over 14,000 physicians and 37,000 registered nurses. As a partner in the National Disaster Medical System, VA is involved in planning, coordination, training and exercises to prepare for a variety of catastrophic events.

VA also provides support to the primary departments and agencies identified in Presidential Decision Directive 62, titled Protection against Unconventional Threats to the Homeland and Americans Overseas. Our Veterans Health Administration supports HHS's Office of Emergency Preparedness in ensuring that adequate stockpiles of antidotes and other necessary pharmaceuticals are maintained nationwide. Four pharmaceutical caches are available for immediate deployment with a HHS National Medical Response Team in the event of an actual weapons of mass destruction incident. We also maintain a fifth cache that is placed on-site at special high-risk national events, such as the Presidential Inauguration. VA also procures pharmaceuticals for the Centers for Disease Control and the Prevention National Pharmaceutical Stockpile Program.

VA is known worldwide as the authority in treatment of stress reactions and post traumatic stress disorder (PTSD). A vast number of highly skilled mental health staff are available for continuing response to the victims of the September 11 terrorist attacks and to respond to future events that psychologically traumatize our citizens.

VA has recently developed a nationwide registry of VA employees who volunteer and are trained to respond to disasters. In the future this registry will provide an inventory of personnel with skills and experience that can be matched to response requirements for both internal (VA) and external emergencies. VHA is developing a national policy and plan for training and equipping our facilities and staffs to manage victims of a WIVID incident. A Technical Advisory Committee JAC) of both VA and non-VA experts was established in early 2000 to advise VA on WIVID issues. The plan will include specific precautionary and response measures to be implemented at all VA facilities. We expect to establish a national policy and initiate system wide implementation before the end of 2001.

Public Law 97–174 authorized VA to furnish health care services to members of the armed forces during a war or national emergency. VA and DoD have established contingency plans whereby facilities of the VA healthcare system would provide the principal medical support to the military healthcare system for active duty military personnel when DoD does not have adequate medical resources under its own jurisdiction to meet medical contingencies. These plans are reviewed and updated annually. This annual review is shared with DoD and a subsequent report is provided to Congress. VA also completes quarterly bed reporting exercises to ensure that procedures are familiar to staff and are ready for implementation on short notice should contingency support become necessary.

EMERGENCY PREPAREDNESS WORKING GROUP

Although VA has plans in place to meet our critical emergency response missions, we know that there are new threats to America that we must address, and address quickly and effectively.

Given that this new threat is real and potent, I immediately formed a senior-level working group to undertake an assessment of the ability of the VA in its entirety to manage a multi-scenario crisis. This group assessed our ability to carry out our missions in case of a biological, chemical or radiological weapons attack. It also examined our capacity for reconstituting our ability to fulfill our missions, if need be.

This assessment has identified some deficiencies and opportunities to improve our ability to carry out all of our missions in today's environment. The challenges we face do not outweigh our overall strengths, and they do not compromise our primary mission to care for the nation's 25 million veterans. But they do represent challenges we must, and will, deal with quickly and appropriately.

In the following, I will outline some of the challenges that the working group has identified. However, in order to deny terrorists any sort of roadmap, I will avoid mentioning specifics at a public hearing. I will certainly be available to discuss such details with members and staff of this Committee after the hearing.

We are now facing the potential of having to respond to terrorists' attacks in the U.S., of providing contingency support to DoD, as well as continuing to care for our patients. Here are examples of our findings:

1. Some regions of VA's health care system would be hard-pressed if they were required to treat military and civilian casualties of chemical or biological agents in addition to carrying out their primary mission of providing health care to veterans.

2. VA needs to enhance its medical preparedness to respond to casualties from chemical and biological agents by providing training to its health care workers on decontamination procedures, and on diagnosis and treatment of chemical, biological and radiation injuries. VA medical centers are likely to play a crucial role in the initial response to an attack in their area. Yet their inventories of equipment and pharmaceuticals may not be adequate to address medical needs in the critical first hours of an attack, especially one involving chemical agents. As a result, VA Medical Centers need substantial upgrades to their personal protection gear, equipment, and training.

3. A call-up of Reserve or National Guard units, or a crisis causing staff to be unable to report to work, could result in a significant medical staffing shortage.

4. A major terrorist attack, especially one involving chemical or biological agents, would require a greater amount of post-traumatic stress counseling for military personnel, veterans, their families, VA employees—notably VA medical professionals and support staffs—and civilians. Long deployments of VA mental health staff could also have an impact on our ability to treat veterans.

5. VA's security forces need to be enhanced in numbers and training, both to manage a domestic crisis requiring medical care, and to protect our veteran patients, key personnel, facilities, and systems.

6. As this committee is well aware, we need to do a far better job securing our information and data bases from cyber-terrorism and to ensure that our key data centers are protected and their data back-up systems fully tested.

7. VBA is dependent on the Department of the Treasury to complete our payment process and issue payments. We need a back-up plan and process in the event that this link is inoperable.

8. Our National Cemetery Administration needs a comprehensive back-up plan to address increased interment workload in the event of an emergency.

9. VA needs to strengthen its communications protocols and its coordination efforts with the Department of Defense.

10. There is a need for a more robust VA headquarters Operations Center, for a stronger emergency operations command and control structure, and for a better-defined plan for mobilizing personnel to relocation sites.

11. We must periodically test our ability to respond to any terrorist attack through more training and periodic exercises.

12. Finally, and most importantly, we need to educate our employees and veterans on the realities of chemical and biological agents and how best to protect themselves.

NEW ACTIONS BEING TAKEN

VA has already begun to meet these challenges. As mentioned above, I immediately formed a working group to conduct a quick, but thorough, review of our readiness. Based on their findings, I have already authorized the following immediate actions:

First, to ensure that we can respond fully in the event of a crisis, I have directed that an immediate review be made of the working group's many recommendations, that those requiring immediate action be identified, and that a fast-track decision process be adopted to implement them within 90 days. VA wants to ensure that it can continue its mission of caring for the nation's veterans, while supporting DoD in case of heavy casualties on battlefields abroad, and supporting FEMA, HHS and CDC and state and local authorities in case of casualties at home. We safeguard, maintain and deliver stockpiles for HHS and CDC and have emergency teams available on call in case of an emergency, particularly one involving biological, chemical or radiological weapons.

Secondly, as you are aware, the VA has the foremost source of medical care assets in the federal government and the largest integrated medical system in the nation. We are enhancing our emergency operations center to keep that system functioning fully in the event of a crisis of any nature. I have ordered this center to institute daily, a round-the-clock coverage, with secure data and voice communications links, to closely monitor VA's operational status, and to track the location of essential personnel for mobilization in the event of a crisis

We will fully support Governor Ridge in fulfilling the mission of providing for homeland security, even as we continue to serve our nation's veterans. Above and beyond close coordination with the Homeland Security Council, we will continue to support DoD, HHS, CDC, FEMA, and state and local authorities in responding to future threats to our homeland.

VA'S FUTURE ROLE

Mr. Chairman, beyond the measures I have discussed today, VA will, no doubt, be a vital force in America's ability to meet tomorrow's challenges. I envision a VA that participates even more proactively in helping our communities maintain a high-degree of readiness in the event of natural disasters or terrorism on our homeland. Our primary mission will always be to serve America's veterans with honor, to acknowledge their sacrifices on our behalf, and to be there for them as they were there for America. In any discussion of homeland defense, I want to assure the Nation's 25 million veterans that we will stand tall with our federal, state, and local colleagues to protect them, their families, and their communities.

The challenges we have defined in our preparedness assessment will also help us develop emergency response training and medical education opportunities that we can share with our civilian health professionals across America. As you know VA Medical Centers are often allied with medical schools and I believe these partnerships—enhanced by our lessons learned—will help tomorrow's health care professionals meet the challenges we have talked about today.

Mr. Chairman, that concludes my statement. Thank you.

My colleagues and I would be pleased to respond to your questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO ANTHONY J. PRINCIPI

Question 1. VA has a great many resources—including staff I consider to be among the best trained in treating PTSD, partnerships with local hospitals throughout the United States, and a nationwide communications system. How can VA and Congress ensure that these resources are used as effectively as possible, at every level, during disasters?

Answer. There is a practical distinction between using VA resources at the national level and using VA resources at the local level. You have correctly pointed out the local partnerships that VA medical centers form in their communities that provide mutual support during local disasters. Associated activities are within the purview of local medical center directors under the guidance of the Veterans Integrated Service Networks (VISNs). At the national level, VA uses its external resources for disaster assistance as prescribed by statutes and interagency agreements. Currently, VA contributes its resources to a national response pursuant to requests from the Department of Health and Human Services (HHS), the lead federal agency for health and medical support.

The VHA medical system, as a whole, therefore, does not have an assigned mission in national disaster preparedness. VHA may provide individuals and medical resources to assist HHS, sign memoranda of understanding with civilian hospitals for the provision of disaster beds, and help train NDMS hospital personnel in the treatment of weapons of mass destruction (WMD) victims. However, VA medical centers are not currently viewed in these contexts as an overall national disaster resource.

VA medical facilities are situated in and around likely future disaster areas and should be prepared to accept "walk-in patients" under the Humanitarian Act. To this end, VA is training its staff to recognize and appropriately respond to victims of chemical, biological, or radiological agents. We must upgrade our decontamination capabilities and establish VA pharmaceutical stockpiles for VA facility response. VA medical facilities are a national asset and should be recognized as such in the emergency planning process.

VA has long years of expertise in the diagnosis and treatment of war-zone-related Post-Traumatic Stress Disorder (PTSD). Since the time of the Gulf War, VA has, with the help of colleagues from the Department of Defense (DOD), developed expertise in the diagnosis and management of acute stress responses in combat settings including training in the assessment of biological, chemical and radiological injuries and mental/emotional responses to such attacks. We have enhanced our learning with experience in various disaster responses including earthquakes, hurricanes, the Oklahoma City Bombing and, most recently, the attacks on the Twin Towers and the Pentagon.

We have developed ongoing relationships with DOD elements and HHS, which includes the Center for Mental Health Services (CMHS) as well as the American Red Cross (ARC) in relation to disaster response. VA's National Center for PTSD (NCPTSD) has, in collaboration with our Readjustment Counseling Service (RCS), created a Disaster Management Manual and trained dozens of VA clinicians in post-event counseling techniques. The NCPTSD, following its mandate for promoting education on PTSD, developed a web site with disaster relief information (www.ncptsd.org/disaster.html), which has been visited thousands of times since the September 11 attacks.

We have identified 400 clinicians from mental health, social work, chaplain service, and RCS who have been specially trained in post-event mental health response techniques. Psychiatrists, psychologists, social workers, nurses, counselors, and chaplains are among the diverse disciplines whose members have received such training. A number of these VA clinicians have received Red Cross training and have deployed with the ARC in the post-September 11 response.

VA's communication abilities include not only web sites as noted above, but also regular teleconferences among staff (e.g., monthly Mental Health Strategic Healthcare Group (MHSHG) PTSD Hotline calls) during which disaster related information is shared. Since September 11, MHSHG and the NCPTSD participated in the Primary Care/Prevention Management (PC/PM) Hotline call and shared information on assessment of PTSD in primary care populations. We also shared information from the PC/PM group on assessment of anthrax via Outlook to MHSHG's Mental Health VISN Liaison and Field Advisory Board e-mail groups so that our mental health clinicians will be able to offer their patients information consistent with that provided by their PC colleagues.

In summary, VA mental health and RCS clinicians are trained in disaster response, and more can be trained in these approaches. We anticipate Network-based planning to facilitate coordination among VA and non-VA facilities in response to the current or future terrorist attacks as well as natural disasters.

Question 2. VA has reported that there are more than 16,000 employees in VHA alone who are members of the Reserves or National Guard members. How many reservists are in other key components of VA? What impact will the call up of some or all of these reservists have on VA's ability to perform its role in an emergency? What contingency planning has VA undertaken to ameliorate the impact, if any?

Answer. The figure provided at the October 16th hearing regarding VHA was incorrect. A further review of information provided to VA by the Department of Defense and verified through VA workforce information systems indicates that as of June 30, 2001, the total number of VA employees subject to military mobilization is 15,149. Of these individuals, 8,316 are members of the retired reserve who are significantly less likely to be mobilized than those in the ready reserve category. Based on these updated figures, VA employs 6,833 ready reservists, of whom 296 were on active duty on November 26, 2001. A total of 6,215 are in VHA, 423 are in VBA, 50 are in NCA, and 145 are assigned to VA's staff offices.

The Preparedness Review Working Group, chaired by Charles Battaglia, the former staff director of the Senate Select Committee on Intelligence and the Senate Committee on Veterans' Affairs, determined that a major call-up would adversely impact VHA. Since many of VHA's reservists are medical professionals, a call-up would compromise VA's ability to provide routine health care for veterans, acute health care for wounded U.S. soldiers, and emergency health care for military personnel and civilians wounded during incidents of domestic terrorism. The impact on VA's other key components is projected to be minimal. Ready reservists are fairly evenly spread throughout the Department's employee population. The workload of

those called to duty would be distributed among fellow employees within each organization.

To ameliorate the potential impact, VA has requested and received from the Office of Personnel Management delegated authority to waive dual compensation (salary offset) for re-employed annuitants and waive repayment of voluntary separation incentive payments (buyouts). Effective October 31, 2001, VA may use these authorities on a case-by-case basis to temporarily replace employees called to active duty in security, patient care, benefit delivery, and related support positions when no reasonable staffing option exists to perform mission-critical duties.

Question 3. This year, VA received funding to train personnel for the National Disaster Medical System (NDMS) for the first time—less than $1 million. The report of VA's Preparedness Review Working Group suggests that a one-time startup funding package of $18 million would be required to equip VA's medical centers for emergencies. Realistically, will these resources be sufficient if VA is asked to take on a more prominent role in the public health response to domestic emergencies?

Answer. VA received $832,000 from HHS at the end of FY 2001 for the purpose of developing a training plan for NDMS hospital personnel in the treatment of WMD victims. VA has agreed with HHS that these funds will be used to conduct a WMD training needs assessment and pilot project. These funds are adequate for the needs assessment and pilot.

Under the agreement transferring the funds, there is no requirement for equipment. This requirement is separate and distinct from the package of the Preparedness Review Working Group. The Preparedness Review Working Group estimated a cost of $118 million to equip VA medical facilities to support emergencies. Much of the $118 million would be spent on Personal Protective Equipment (PPE) for health care workers, establishment of decontamination facilities, and to create VA pharmaceutical caches to support VA medical facilities in the event of an attack. Although this estimate represents a one-time start up cost, there would be associated recurring costs with maintaining readiness and continued training. VA has already recognized, based on increasing drug costs that these costs will escalate. VA is working to re-estimate this cost.

Question 4. As you confirmed at the October 16 hearing, interagency coordination frequently results in less than ideal partnerships. Although VA now has a role at the newly created Federal Office of Homeland Security operations center, many previous interagency public health preparedness planning efforts have excluded VA. What steps are needed to ensure that VA has a place at the planning table with FEMA, HHS, DOD, DOJ, and other critical agencies?

Answer. The President's Executive Order establishing the Office of Homeland Security specifically names VA as a contributing agency to the Homeland Security Council. In addition to our presence at the Homeland Security Operations Center, VA is actively participating in the Citizens Preparedness Task Force as well as the Homeland Security Council's Deputies Committee and Policy Coordinating Committee. VA is not positioned to be a lead agency for public health preparedness, but it does provide considerable support to other Federal agencies in the event of disaster and emergency. Our primary mission remains to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support and recognition earned in service to this Nation. Nevertheless, VA takes its crisis response and support role very seriously, and has been very active in interagency emergency planning efforts including FEMA's Interagency Advisory Group (IAG), Continuity of Operations Working Group (CWG), and Federal Response Plan Emergency Support Function working groups. We are making progress in expanding our role in public health preparedness, especially in light of our participation in the Homeland Security Policy Coordinating Committee. We are actively working to join other public health related interagency working groups and policy coordinating committees. We expect that our role in public health preparedness will continue to expand; especially as other Federal agencies recognize VA's potential as a source of emergency resources, such as medical supplies and pharmaceuticals, as well as response capabilities.

Question 5. The misunderstanding between on-site responders and VA staff during this summer's flooding in West Virginia illustrates the breakdown between agreements made at the agency level—such as VA's Memorandum of Understanding with the American Red Cross—and their implementation at the State and local level. Neither local VA employees nor the state public health professionals knew that this interagency agreement existed, nor what sharing of resources it might allow. What can be done to ensure that interagency agreements made between VA and its partners at the national level are communicated to state and local stakeholders? How does VA headquarters propagate innovative sharing programs developed by individual VA facilities or networks and their community partners?

Answer. At the national level, the process to provide disaster relief and services to states and local governments by federal departments and agencies is through the Federal Response Plan (FRP), which implements the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended. The memorandum between the Department of Veterans Affairs (VA) and the American Red Cross (ARC) was developed to provide a written description of mutual support and promote understanding and cooperation between VA and the ARC. While promoting volunteerism among VA employees, it also underscores that the FRP is the vehicle through which VA will provide requested resources made by or through the ARC for disaster relief. Currently, VA has no national policy regarding either the promotion or restriction of local VA health care facilities in developing independent support agreements, as long as they meet guidelines and legal requirements established by the Veterans Integrated Service Network (VISN).

As a result of a meeting held in October of this year between West Virginia VA health care facilities, state representatives, and a representative from your staff, a memorandum of understanding (MOU) is under development between VISN 6 and the State of West Virginia to provide VA assistance for counseling and medical services for future disasters during the interim period prior to a Presidential Disaster Declaration. A new Emergency Management Guidebook, under development for the Veterans Health Administration, will include guidance on local MOU development and describe mechanisms (existing plans and agreements) needed to meet local requests for assistance in lieu of the existence of a local agreement. In fact, an entire chapter is being dedicated to community support activities in disasters and emergencies. It will include mechanisms for informing local stakeholders of national agreements.

Question 6. How can VA most effectively use its partnerships with other federal agencies to supplement its own emergency preparedness efforts? For example, what technologies could VA adapt from Department of Defense programs to develop biological/chemical sensors, rapid diagnostic assays for biological exposures, or cybersecurity protections?

Answer. VA's WMD preparedness is consistently enhanced by its collaborative efforts and partnerships with other departments and agencies. Through an Inter-Service Support Agreement with the DOD, the Domestic Preparedness hospital provider training was presented at 40 VA medical centers in the past year. Through a similar agreement between VA and DOD, a 12-hour nationwide satellite broadcast (featuring DOD and VA faculty) on "Medical Response to Chemical and Biological Agents" aired in November and December. Other broadcasts on chemical, biological, and radiation injuries have been aired in the past two months and have included faculty from VA and DOD.

Question 7. We know that if VHA is to perform its fourth mission, and its primary mission, its doctors need good information on what has happened to troops in the field. How is VA working together with the Department of Defense to create information tools that can be used easily by both VA and the military?

Answer. The key to finding out what has happened to troops in the field is maintaining access to a comprehensive medical record on DOD personnel to include: (1) health status prior to deployment; (2) immunizations and prophylactic medications received during deployment; (3) medical encounters while deployed; (4) exposure assessments of hazards encountered while deployed; and (5) health status upon redeployment. DOD has made significant progress in developing both policies and the information tools needed to assist in executing those policies. Deployment health information is maintained in the Defense Medical Surveillance Activity, and VHA has access to that database. In addition, the Government Computerized Patient Record (GCPR), which is a joint VA/DOD/HHS information management/information technology project, will facilitate electronic transfer of health information from a DOD database to a VHA database. At present, some health information is available to be transferred electronically, but additional efforts are underway to expand this capability.

Another information tool, a health survey, is being employed in a comprehensive collaborative VA/DOD research project, the Millennium Cohort Study. This is a multi-year scientific protocol that will assess the consequences of deployments on the health of a cohort of 100,000 military personnel. As results are made available from this study, VHA will be better able to address veterans' health needs.

In addition, the DOD has developed a new system for military casualty management and movement to final destination hospitals in the United States, including those of VA. The United States Transportation Command Regulating and Command and Control Evacuation System (TRAC^{2}ES) includes a web-based information system that provides details on the patient's medical condition from time of entry into the system until delivery at the final destination hospital. The system also provides

the ability to update patient information while the patient is enroute. VA has been involved with DOD in coordinating and implementing this system to ensure that VA health care facilities that will be receiving active duty casualties will receive the latest information on arriving patients.

We believe that the Military Veterans Health Coordinating Board, which includes representation from VA, DOD, and HHS, can play an important role in obtaining information on experiences and exposures of U.S. service personnel in the field, as well as assisting in the identification of resulting health care needs. Independent, non-govern mental organizations such as the National Academy of Sciences also provide important scientific information that assist VA in carrying out its missions. VA is working with DOD on tools to disseminate information in user-friendly forms, including clinical guidelines, pocket cards, self-study programs, and satellite teleconferences. Of course, the cooperating Departments will implement all appropriate measures to ensure the privacy and security of sensitive personal information.

Question 8. Given the military's history of poor medical surveillance of deploying troops, what proactive steps can VA take to prepare to address the needs of returning service members?

Answer. Following the Gulf War, VA has worked closely with DOD to address issues related to deployment health and surveillance. For example, the VA has collaborated with DOD to develop clinical practice guidelines to assess health concerns among military personnel following hazardous deployments, and to evaluate military personnel and veterans for chronic fatigue syndrome and fibromyalgia.

In May 2001, VA announced the establishment of two dedicated research centers, the Centers for the Study of War-Related Illnesses, to respond to the health problems of military veterans and to improve the health care of active duty personnel and veterans with war-related illnesses. Because these illnesses have to be studied with the same scientific rigor American medicine has applied to other health problems, the Centers have four major components focusing on veterans' health issues: research, clinical care, risk communication, and education. The two Centers are located at the East Orange, NJ, and Washington, DC, VA Medical Centers.

A major factor in influencing VA's decision to establish these centers included the need to develop better ways of meeting the health needs of war veterans, particularly veterans with difficult to diagnose symptoms. Historical studies demonstrate that since at least the U.S. Civil War, veterans have returned home with unexplained symptoms. From this experience we have learned that combat casualties do not always result in obvious wounds, and that some veterans inevitably return with difficult to diagnose yet nevertheless debilitating symptoms. We do not yet fully understand the causes of many of the illnesses suffered by veterans returning from wars and hazardous peacekeeping missions.

In addition to the new research centers, VA is committed to sharing with America's military veterans and their families the information that we have relating to their health problems and concerns. VA's Office of Public Health and Environmental Hazards has published a national newsletter regarding Agent Orange issues for 19 years and a national Gulf War newsletter for about 9 years. This office also has produced fact sheets, brochures, videotapes, posters, and web pages on these subjects.

VA is currently planning similar publications for veterans serving in Afghanistan and surrounding areas. The first product will be a new fact sheet and brief on health issues related to service in Afghanistan. It will cover infectious diseases and environmental hazards that U.S. service members may encounter in that region of the world.

Question 9. Have VA's existing emergency preparedness programs and recommendations been implemented equally throughout the service networks?

Answer. VA has established national emergency preparedness programs and provided implementation guidance commensurate with existing directives. For example, each VISN has a separate Service Support Agreement (SSA) with the Emergency Management Strategic Healthcare Group (EMSHG) defining mutual support. In essence, EMSHG provides the emergency preparedness expertise and guidance in return for administrative support. The implementation of emergency preparedness programs has relied heavily on VISN and medical facility directors' prioritization related to the use of limited resources for associated equipment, training, and exercises. Consequently, the status of these programs varies somewhat by location.

In order to develop more consistent implementation, VHA is developing policies and guidance in the form of a Directive to define the requirements that all VISNs must meet. VHA is also developing a Guidebook to provide sample policies, procedures and methods to meet new JCAHO standards and also ensure more consistent outcomes across all facilities.

Question 10. There is a delicate balancing act to be pursued in readying VA medical centers for surges in patient demand. How will you ensure that you have suffi-

cient staff and medical supplies on hand to deal with a disaster without depleting VA's already limited resources to care for veterans?

Answer. A surge in medical requirements within VA could come from two primary sources, local casualties who come to VA medical centers, or the VA/DOD Contingency Hospital System, which accepts military casualties returning from overseas.

Under the VA/DOD Contingency Hospital System, some stabilized patients would be transferred from designated Primary Receiving Centers to Secondary Receiving Centers and other steps, such as postponing elective surgeries, would be implemented to free medical center assets. VA's Prime Vendor system could be used to obtain necessary supplies very quickly. Overseas casualties would be expected to arrive in groups through available air transportation, allowing some time for VA medical centers to adjust staffing and supply levels. There is no doubt, however, that the greater the requirements, the greater the strain will be on the VA healthcare system.

Question 11. How can Congress modify existing law so as to gain a better estimation of how many active duty or civilian casualties VA might be able to treat during a conflict or domestic crisis, rather than simply counting beds as under current law?

Answer. In order for hospital beds to be an asset in an emergency crisis or contingency, they must be "staffed," and equipped beds, and the capability must exist to transport patients to those beds expeditiously. In other words, the medical capability must exist and be accessible to the patient. However, the ratio of related services to beds is a difficult measurement given that medical and relative capability is often subjective, such as in the case of multi-purpose hospital beds. In addition, accessibility will likely be dependent on air transport availability that may be unpredictable. Estimates may be improved with the use of standardized reporting requirements and periodic evaluation of resultant data.

Question 12. Given VA's existing communications infrastructure (including its telehealth capabilities), its broad geographic presence, and its pivotal role within the Federal communications centers system during presidentially declared disasters, do you see a larger mission for VA in fortifying communications between Federal, state, and local responders? Is there a need to highlight VA's current communications functions to other Federal agencies and state and local front-line responders?

Answer. VA facilities are integral parts of each community, the hospital systems, cooperative medical education efforts, and mutual support agreements at the local government level. In emergency medical planning, VA's Area Emergency Managers (AEMs) routinely work with local, county, and state officials and cooperate in many joint training and exercise initiatives.

With its communications infrastructure, clinical resources and telehealth capabilities, VA is in a position to play an increased role within the federal communications centers system during presidentially-declared federal disasters. We have asked EMSHG to consider these issues and to make appropriate recommendations in this area.

Chairman ROCKEFELLER. Can you just describe to me the interagency planning process? I hope that you can do this without damaging yourself, your agency, and your future working relationships, but I have been stunned in the last 4-plus weeks at the number of agencies that seem to have fully designated power to do virtually anything. I am wondering what happens when agency leaders sit down and decide, all right, who is going to do what? How are resources going to be allocated?

In other words, what I am really asking you is, from the VA's perspective, when you went to HHS, who decided what responsibilities and powers VA would have? I have a feeling that the VA has been left out of some of that decisionmaking. You do not have to answer that, but that is my view in what they bring to the table in these situations. How does your view of the interagency system of response work? Has it been as ad hoc as I think? Maybe it has been ad hoc because there has been no other choice, there not having been a similar experience. What are your views?

Mr. PRINCIPI. I do not know, but certainly a similar experience in recent history, the Galveston floods that killed hundreds of thou-

sands of people. I believe that the response, the interagency cooperation, the response of this crisis was quite good from my perspective.

I think it is very important that VA be at the table, and not for recognition or credit purposes, but to realize VA is the largest health care system completely under Federal control, 1,200 sites around this Nation and in most communities in America, with 200,000 people under Federal control that may be used to respond to these crises. So I think it is very, very important that VA be at the table and I am optimistic under Director Tom Ridge's leadership that VA will be at the table, perhaps not as a member of the permanent council, but certainly to discuss the role we can play in responding to crises.

Perhaps Dr. Murphy, from her experience in recent years at VA, can talk about how we work with the Federal Response Plan and the National Disaster Medical System in a coordinated way.

Chairman ROCKEFELLER. And when you do that, could you answer a further question, Dr. Murphy? I apologize for not introducing you. There has been an awful lot of talk about PTSD and that fear is not linear, it comes in waves and it affects different people in different ways at different times and you could be far away from it and be affected, be close to it and not be affected. But PTSD is going to be a very major part of the psycho-social work which is done on all of this. There is nobody that even touches the VA in terms of PTSD.

I went through an hour's meeting this morning in which all these things were discussed and VA was never mentioned. They were not there and they were never mentioned. I am wondering what your thoughts are about that, even as you respond to what the Secretary asked you to.

Dr. MURPHY. First, related to the Federal Response Plan, I think the plan was very good in that it organized a coordinated response to a national emergency and designating particular agencies to take the lead. As far as it went, I think when employed, the Federal Response Plan can work well.

The VA has three, or actually four areas of responsibility under that plan in the emergency support functions, including public works and engineering, mass care, resource support, and health care and medical services. We are not the principal agent in any of those areas. We are a support agency.

For the mass care, the American Red Cross is the principal, and for health and medical services, the principal agency is HHS. Sometimes there is confusion between those two functions. Let me give you an example related to trauma counseling.

We recently got a request from the American Red Cross that they needed some trauma counselors, and, in fact, that is not in their principal area or in their emergency support function. The request should have come through HHS under the Federal Response Plan. We cannot instruct VA employees to volunteer to provide trauma counseling under the auspicies of the American Red Cross. Many VA employees, thousands of them, stepped up and wanted to volunteer their services after September 11. However, VA has no authority to officially direct our employees to volunteer, either to

the Red Cross or other non-government organizations. We do not have that authority.

In order for us to respond to that request under the Federal response plan, the request must be for Health and Medical Services Emergency Support Function through HHS. We can find ways to work around some of those authorities, but sometimes it does create significant logistical difficulties. In general, we can make it work. With effort, make it work well.

Related to PTSD and trauma counseling, we have not yet seen the full impact of the injury that resulted from the attacks on September 11. Clearly, we have learned from our experience with veterans and also from the Oklahoma City bombing, we do not expect the full impact of this to begin until 3 to 6 months after the attack. That is when the full impact of the trauma will start to be seen and when the real peak in people requiring mental health services will occur.

We know that after the Oklahoma City bombing, the number of requests for mental health services more than tripled in our veteran population. If you consider the number of people who are impacted by this event, either directly in New York or across the country by watching it on TV, the mental health impact and the injury related to that is going to be enormous. We need to start working together to plan for that impact.

Chairman ROCKEFELLER. Thank you.

Senator Specter?

Senator SPECTER. Thank you very much, Mr. Chairman, and thank you for convening this hearing. Earlier today, FEMA Director Joe Allbaugh appeared before the Environment and Public Works Committee discussing this subject, and the Appropriations Subcommittee on Labor, Health, Human Services, and Education has scheduled a hearing for Friday to look into what sort of appropriations are necessary. I think it is very important—as do you, as shown by your having convened this meeting—to focus on what areas of responsibility VA will have, and I think it is also helpful to VA to have these kinds of questions so that it may rethink where it is going.

When the Gulf War was upon us, I traveled around the country. I was ranking member then—I am still ranking member, there was a hiatus in between, however——

[Laughter.]

Senator SPECTER [continuing]. And I recall visiting hospitals at that time. It was a decade ago. My fondest recollection was going to the Veterans Administration hospital in Wichita, KS, if I may digress from relevancy, if that is ever a concern here in the Senate, where my father was treated in 1937 when a spindle bolt broke on his truck and it rolled over on him, crushing his arm, and I used to ride a bicycle miles out to the VA hospital, which was way beyond the outskirts of town. Now it is part of the city of Wichita, and I found the records when he was admitted. I think it was August 7, 1937.

But coming back to relevance, at that time, the VA was concerned about the possibility of having many servicemen and women coming back. That appears unlikely now, hopefully, that we will not be fighting that kind of war. But should the situation change,

would you be in a position to have hospital space available to treat wounded service personnel if this war on terrorism takes that turn?

Mr. PRINCIPI. We certainly can care for a certain percentage of those servicemen.

Senator SPECTER. Well, Mr. Secretary, that depends upon how many there are, as to what the percentage is. But in absolute numbers in beds, how many beds could you make available if the necessity arose?

Mr. PRINCIPI. We have reported to DoD that we can make 7,500 beds available within 72 hours of request. Now, I have the authority as Secretary to give a priority to servicemen and women wounded in battle over non-service-connected veterans. They cannot take precedent over service-connected disabled veterans, but it is conceivable that based upon the number of casualties, we could increase that number over a period of time. We have roughly 20,000 acute care hospital beds. We have additional bed capacity if those beds were staffed. So certainly with 72 hours or about 72 hours, 7,500 beds would be made available.

Senator SPECTER. With respect to the Office of Homeland Security that has been mentioned here, last Friday, the Government Affairs Committee held a hearing on legislation which has been introduced to give some structure to what is going on there. Senator Lieberman and I introduced legislation last Thursday on the concern that even though Governor Ridge has the confidence of the President and people may say no to him and not to the President, it is hard to go to the President every time there is an interagency dispute.

Would you confirm that? When you have interagency battles, are you able to go to the President with regularity to have them resolved either for or against you?

Mr. PRINCIPI. I pick and choose my battles that I take to the President very carefully, of course.

Senator SPECTER. Are you picking and choosing your questions and answers, too? [Laughter.]

Mr. PRINCIPI. If need be, I will go to the President and fight for my Department, but——

Senator SPECTER. Have you been asked by Governor Ridge to join his effort? Has he sought your resources, if not your counsel?

Mr. PRINCIPI. No.

Senator SPECTER. How about the issue of pharmaceuticals? That was a big topic. Senator Rockefeller and I spent a good part of the morning trying to figure out what is happening with the anthrax attack on Senator Daschle, and it is a little hard functioning today since I do not have an office. We are displaced. My staff is coming under the displaced worker legislation the way it looks now. [Laughter.]

But do you have antibiotics——

Mr. PRINCIPI. Yes, we do.

Senator SPECTER [continuing]. In large quantity? How many people could you take care of if the worst came on an anthrax problem?

Mr. PRINCIPI. Yes, we do. I will ask Dr. Murphy if she has the precise number. We stockpile four caches of pharmaceuticals, med-

ical/surgical supplies for the National Disaster Medical System. We do a lot of the procurement of the pharmaceuticals for HHS. We have antibiotics, of course, in all of our medical centers. As for the number of patients we can treat I will defer to Dr. Murphy.

Dr. MURPHY. VA manages the Office of Emergency Preparedness and CDC pharmaceutical caches, but would deploy them at the instruction of those two organizations. We do have limited supplies of pharmaceuticals and other medical supplies at our medical centers.

One portion of the plan that we have developed at Secretary Principi's request recommends that we have caches of pharmaceuticals at each of our medical facilities for use in carrying out our primary mission, veterans health.

Senator SPECTER. And how many people can you care for if the need arose?

Dr. MURPHY. I would be happy to provide a separate briefing on the full scope of what we are proposing and the number of people that we would propose to treat.

Senator SPECTER. Thank you. My red light is not on. I see that Senator Rockefeller's chairmanship has a kindler and gentler lighting system. The red light does not go on.

Chairman ROCKEFELLER. Well, I was talking too much and not giving Fran and Tony enough time to answer, so I intervened that way. Senator Nelson?

Senator NELSON. Thank you, Mr. Chairman.

Obviously, there is a lot of concern about pharmaceuticals and being in a position to back up not only the Department of Defense, but also for public concerns, as well. Who is responsible for determining the medical supplies that are being kept at the National Pharmaceutical Stockpile and is there a process that does not involve national security for determining what medical supplies should be included and to what extent, quantities and procedures in place?

Dr. MURPHY. Those caches are actually under the control of HHS. We do the procurement for the CDC caches and we actually manage the OEP caches. CDC has a group of experts who determine the specific contents of each of those pharmaceutical stockpiles will be. I think it is well developed and well focused.

Senator NELSON. In terms of the quantities and what might be available in the case of some critical outbreak, who determines what the supplies might be and what the potential outbreak requirements might be?

Dr. MURPHY. Again, the determination for the national response is made by HHS, and I believe that Secretary Allen is prepared to tell you about some recent changes that they have proposed, going from 2 million doses currently available in the CDC caches to 12 million, but I will let him give you further details on that.

We would, within our Department, determine the content of our local supplies and also the quantities required for our immediate response for our staff, our veterans and any walk-in patients.

Senator NELSON. So there is coordination between what would be internal or for veterans and what would be external beyond veterans' needs?

Dr. MURPHY. Yes. As VA developed our internal guidance on caches, we reached out to the Department of Defense and HHS experts and coordinated the response with them.

Senator NELSON. Now, would that apply to any American civilians living abroad, such as diplomats in American embassies in foreign lands?

Dr. MURPHY. The State Department would have jurisdiction over that particular issue and I do not know enough about the details of their system to speak knowledgeably about it. Maybe Secretary Allen can answer that question.

Senator NELSON. Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Nelson.

I want to again pursue what I brought up before and then give one other question. I am worried that VA is not at the table enough. Tell me if you disagree, and there is an HHS secretary coming right up afterwards and he will have a chance to shoot me down and put me in my place. But I think it is true to say that HHS has been wanting to get into the emergency preparedness business for a long time and they are there. My question is, are they bringing the public health community sectors with them that they need?

My judgment is that VA is not at the table. As you said, Mr. Secretary, VA is the largest health care system in the entire country, with everything at its disposal, and you are not—in my judgment—at the table enough when decisions are being made. I place part of that blame upon HHS and their unwillingness to reach out. I do not understand that. I think Tommy Thompson is one of the President's great, great appointments, like you. I think he is terrific. I was thrilled when he was nominated. But I do not understand that and I want to get your view on that.

Second, Julie Fischer just gave me this perfect segue, Fran, for you. You indicated that PTSD does not take place for 6 months, in that range, but mental health stress, all kinds of other things surely do. You have elevated PTSD to a much more sort of formal description than I was thinking of. I was thinking of shorter-term needs.

We had in West Virginia an experience during our floods that I want to relay to you. During those floods, the VA mental health counselors wanted to volunteer but they could not. They could not because, No. 1, the American Red Cross—to which I made my contribution and everybody else did and they did a wonderful job—would not answer their telephone calls. Second, unless VA staff were certified by the Red Cross, they could counsel nonveterans. Well, I do not assume that any of those VA folks who wanted to go out and be helpful in a devastated one-third of West Virginia were certified.

This kind of thing makes me very, very angry because it shows how rigid we can be when all circumstances call for us to become less rigid and adjust and, in fact, for people like the Secretary and yourself to be able to make ad hoc decisions for which you may later be dragged across the carpet, but you could care less because you know you did the right thing. You know you did the right thing.

I remember once—not just once—when I was Governor that we had terrible floods in 1977. I condemned coal property up on a mountain. I condemned it. Nobody had ever done that before. It was considered heretical. Four years later, out of the how many millions dollars being spent by lawyers on all sides, the Supreme Court upheld us. The land was condemned. We built houses. People moved up there, lived there, got out of the flood plains.

Now, I am not trying to make a hero of myself, but I am simply saying sometimes you have to do things which are not in anybody's book. They are odd. They cause tensions. They cause people to get upset. It does not make any difference if you are doing the right thing because we have never been through September 11 before.

And I want to get your response, and I hope the light will go off so as not to embarrass me again, about why it is that we do that. People are looking to the Federal Government for leadership and they are finding great leadership and you have done great things, but we could be doing much better things and we ought to be. The whole question of making government less rigid, letting us cross barriers, paying the consequences later, all of that strikes me as a normal consequence and responsibility for a post-September 11 behavior.

Mr. PRINCIPI. I agree with your assessment about Secretary Thompson. I think he is indeed one of the finest cabinet secretaries I have the privilege of serving with. I believe as Governor of the State of Wisconsin, he had a deep appreciation for the role of VA and I am confident we are going to see VA play an important role alongside the Department of Health and Human Services in responding to these tragedies.

I agree with you, Senator. VA is a national resource. It is very large. Again, it is under Federal control and it would be a tragedy if we did not utilize this Department to its maximum ability to respond to crises. So you are right.

Are we at the table as much as we should be? Probably not. Is there good cooperation? I think so, and I expect to ensure that our voice is heard and that we can play a role. Again, we do not need to take the lead role. That is the role for HHS. But we need to be there as their partner in responding to tragedy because it is going to take all of the elements of government to come together if we are going to succeed. As I indicated at the outset, if there were more casualties, I think it would have overwhelmed the whole system, so we are all going to have to be in this together to respond to this type of tragedy.

As far as crossing the line and doing what is right, I agree with you there. I think Mayor Giuliani demonstrated——

Chairman ROCKEFELLER. He sure did.

Mr. PRINCIPI. The whole command center was in the World Trade Center and it was destroyed, and within 24 hours, he mobilized that city and created a new command center and just said, "Make it happen." He did not care how it happened, but within 24 hours, three football fields were at the Federal agencies, State and local agencies, military, VA, Red Cross were all on the same pier providing services to the citizens of New York. That would not have happened without strong leadership who said, "Make it happen."

Our people in New York did that. They pulled citizens off the street. They did not ask, "Are you a veteran or are you a non-veteran?" They just said, "Do you need help? We are here to help you." That is the kind of leadership I look for in VA and that is what we are going to do over the next 4 years.

Chairman ROCKEFELLER. He is well-knighted, Mayor Giuliani. He is.

Did you have any further questions?

Senator SPECTER. No, thank you, Mr. Chairman. I do not.

Dr. MURPHY. I would say just a few more words about PTSD. We have approximately 400-plus trauma counselors in VA and thousands of mental health professionals. The American Red Cross requires that their certification program be completed by people who wish to volunteer for their activities.

Chairman ROCKEFELLER. Why?

Dr. MURPHY. Well——

Chairman ROCKEFELLER. I mean, what is so sacred?

Dr. MURPHY. They have a training course that they believe in.

Chairman ROCKEFELLER. That is standard.

Dr. MURPHY. It is standard for the Red Cross. When a VA employee volunteers for the American Red Cross, that employee is no longer under our jurisdiction as VA staff they become a private citizen volunteer. In fact, as a volunteer they no longer have the liability protection of a Federal employee because they are functioning outside of their Federal responsibilities and as a volunteer to the American Red Cross. The Red Cross uses their certification as an entre into their system and as a means to ensure that their volunteers have the minimum skills required.

Chairman ROCKEFELLER. I am sorry. I find that repugnant. They cease to be VA employees in order that the Red Cross can count them as volunteers, and, of course, therefore they would not do that because they work for the VA.

Dr. MURPHY. Many of our employees do volunteer their time under the auspices of the American Red Cross. Secretary Principi has also given us the authority to provide humanitarian assistance in New York and in Washington under our own services and authority.

I did not mean to suggest that PTSD occurs only in the chronic condition but that there is a peak later in time. Clearly, there is an acute form of PTSD and stress response. In fact, I have recently heard an astounding statistic that there were 1.9 million new prescriptions for anti-depressants in the country since mid-September and over two million anti-anxiety drug prescriptions and sleep medications prescribed. Clearly, the 9/11 events are already having an impact and we need to address the acute problems, but I would like everyone to recognize that the full magnitude of injury has not yet been realized.

Chairman ROCKEFELLER. That is extremely helpful. I thank you both very, very much. These hearings are unfair to you because you do not get to say what you really want to say——

[Laughter.]

Chairman ROCKEFELLER. No, no, I am not doing my usual OMB number. I am just saying that there are more things that you would like to say—for example, what you just said, which is very,

very helpful. The hearing process is not friendly to allowing you to say that and I regret that.

The next panel is the Honorable Claude Allen, who is Deputy Secretary of Health and Human Services; the Honorable David Chu, Ph.D., Under Secretary of Defense for Personnel and Readiness; and Bruce Baughman, who is Director of the Planning and Readiness Division, Readiness, Response, and Recovery Directorate of FEMA.

Gentlemen, you are all welcome. Your statements are in the record and we welcome, with discretion of time, what you have to say.

STATEMENT OF CLAUDE A. ALLEN, DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES

Mr. ALLEN. Mr. Chairman, Senator Specter, members of the committee, thank you for this opportunity to appear before you. I will try to be very brief and to address your question specifically as it relates to the mission of HHS and our relationship with the Veterans Administration, DoD, and other partners.

The events of September 11 clearly bring us to a point that we are looking at our preparedness, our state of readiness, and I think that what was demonstrated there is that the system does work, that there are areas where the system needs to be improved, but it certainly does work.

With regard to what happened in New York, is New York City took the lead in responding. They were the first to respond and they were the first to make decisions. The State brought their resources to bear, at that time. At the Federal level, we positioned our resources there, as well. In fact, 2 days after that event, Secretary Thompson and I traveled to New York. We met with Mayor Giuliani and his Health Director. We met with the State Health Director, Commissioner of Health, and other professionals and were able to be responsive on the spot to their needs with regard to providing them with epidemiologists. Some of our epidemiological officers are positioned in New York to do surveillance of conditions coming into the emergency rooms. We were also able to begin working with them in response to some of the immediate mental health challenges that were incurred, in addition to beginning to address the longer-term questions of post-traumatic stress syndrome.

What I want to say is that while the Federal response there was very quick and very swift, it was very much in the background. Much of what was going on on the front lines was led and headed appropriately by the local government and the State government. But with the assistance of VA and other Federal partners, we were present and continue to be present there in providing services and assistance.

Under Secretary Thompson's leadership, as you already identified, our Department has changed considerably in how we are working and moving toward addressing the needs of America in this era of terrorism and bioterrorism. And as you know, Congress will appropriate $20 billion toward recovery efforts and preparedness measures. To ensure the safety and well-being of Americans here at home and abroad, the administration will request more

than $1.5 billion in new funds for bioterrorism preparedness at the Department of Health and Human Services. When combined with the administration's original request of $345 million, HHS will be provided a total of $1.8 billion in fiscal year 2002.

Let me highlight just a few areas in which this money will be spent. Part of the money will go directly toward augmenting the National Pharmaceutical Stockpile, which will include about $643 million to expand the existing stockpile. This is going to include adding to the already existing eight push packs of medicine and supplies that are stationed throughout the Nation. Indeed, one of those push packs was moved to New York within 7 hours of the disaster. This money will also be used to provide enough anthrax antibiotics for treatment of 12 million people for a 60-day period, which is an increase from our current supply of 2 million coverage with a 60-day supply. In addition, we will also initiate additional procurement of smallpox vaccine and other essential pharmaceuticals.

Our relationship with VA and DoD and other Federal partners is one that is very important to the Department. Our preparedness in domestic circumstances is very different than what the VA's mission is with regard to supporting our veterans. While HHS is really the lead under the Federal Response Plan for a domestic health response, that is done in coordination with VA and DoD.

Again, a good example of that is the floods in Houston just last year. The VA was a very crucial partner in responding to that emergency. And indeed, what they were able to provide there included nothing short of providing basic hospital services when that area was not able to handle the treatment of people needing care.

And so there are many areas that we will find that VA and its services—its abilities—will be brought to the fore in a time of emergency, but it all depends on what the immediate need is from the local and State government. We are positioned to move anywhere in the country, but we will work closely with State governments and local governments to do that and not undermine what might be a very good system already in place. We will simply be there to support and to augment that.

Let me stop there and see if there are any additional questions that you may have that I can answer, but I would be glad to address any specific issues you may have.

[The prepared statement of Mr. Allen follows:]

PREPARED STATEMENT OF CLAUDE A. ALLEN, DEPUTY SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee, I am Claude A. Allen, Deputy Secretary of the Department of Health and Human Services (HHS). I am pleased to be here today to discuss the role of HHS's Office of Emergency Preparedness (OEP) in the Federal Response Plan.

The nation watched in disbelief, on the morning of September 11th, as American Airlines flight #11 crashed into the North Tower of the World Trade Center. As we all know, shortly thereafter, United Airlines flight #175 crashed into its twin building. Within minutes, we had activated our Department's Emergency Operations Center (EOC), knowing that our Department and our National Disaster Medical System (NDMS) partners in the Department of Veterans Affairs (VA), the Department of Defense (DoD), and the Federal Emergency Management Agency (FEMA) might be called upon to assist New York City in its response.

By the end of that tragic morning, with the almost simultaneous crashes of American Airlines flight #77 into the Pentagon, the crash of United Airlines flight #93

in Pennsylvania and the collapse of the World Trade Center buildings, Secretary Thompson had ordered activation of the entire NDMS, including notification of all of its 7,000 volunteer health workers and 2,000 hospitals. Verbal mission assignments were being obtained from FEMA, and teams were beginning to prepare to move during that day to staging areas around New York City and within Washington, D.C. It is a day that witnessed heroic actions, rapid responses, and profound grief.

HHS PREPAREDNESS AND RESPONSE

HHS agencies that play a key role in our Department's overall bioterrorism preparedness include the Office of Emergency Preparedness (OEP), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the National Institutes for Health (NIH). HHS is the primary agency responsible for health and medical response under FEMA's Federal Response Plan. This plan provides HHS, along with FEMA, 26 other Federal Departments and agencies, and the American Red Cross, with a framework to respond to an emergency.

The broad goals of a national response to an emergency, including acts of terrorism, or any epidemic involving a large population, are to detect the problem, control the epidemic's spread and treat the victims. At HHS, our efforts are focused on improving the nation's public health surveillance network to quickly detect and identify the biological agent that has been released; strengthening the capacities for medical response, especially at the local level; expanding the stockpile of pharmaceuticals for use if needed; expanding research on disease agents that might be released; developing new and more rapid methods for identifying biological agents and improved treatments and vaccines; improving information and communications systems; and preventing bioterrorism by regulation of the shipment of hazardous biological agents or toxins. HHS has also worked to forge new partnerships with organizations related to national security.

We are striving at HHS to strengthen our readiness and response, and our ability to respond has been greatly improved over the last several years. The system is not perfect, however, and we must continue to accelerate our preparedness efforts.

As you know, much of the initial burden and responsibility for providing an effective response by medical and public health professionals to a terrorist attack rests with local governments, which would receive supplemental support from state and federal agencies. However, if a disaster or disease outbreak reaches any significant magnitude, such as what occurred on September 11th, local resources could be overwhelmed and the federal government may be required to provide protective and responsive measures for the affected populations.

OFFICE OF EMERGENCY PREPAREDNESS ROLE IN FEDERAL RESPONSE

Within my Department, the Office of Emergency Preparedness is the primary agency responding to requests for assistance and resources. OEP's main function is to manage the National Disaster Medical System (NDMS) as well as the Public Health Service Commissioned Corps Readiness Force, which could be called into action depending upon the severity of the event. One of OEP's missions is to manage and coordinate, on behalf of HHS, the federal health, medical, and health related social service response and recovery to major emergencies, federally declared disasters and terrorist acts. OEP directs and manages Emergency Support Function #8 (health and medical services) of the Federal Response Plan. This includes coordinating the activities of 12 other federal departments nationwide, including the Departments of Veterans Affairs, Defense, Transportation, Energy, and Agriculture, the Environmental Protection Agency, and others.

When there is a disaster, FEMA, as the Nation's consequence management and response coordinator, tasks HHS to provide critical services, such as health and medical care; preventive health services; mental health care; veterinary services; mortuary activities; and any other public health or medical service that may be needed in the affected area. OEP, as the Secretary's action agent, will direct NDMS, the Public Health Service's Commissioned Corps Readiness Force, and other federal resources, to assist in providing the needed services to ensure the continued health and well being of disaster victims.

The National Disaster Medical System is the vehicle for providing resources for meeting the medical and mental health service requirements of ESF #8, including forensic services. Begun in 1984, NDMS is a partnership between HHS, VA, DoD, FEMA, state and local governments, and the private sector. The System has three components: direct medical care; patient evacuation; and the non-federal hospital bed system. NDMS was created as a nationwide medical response system to supplement state and local medical resources during disasters and emergencies, to provide

back-up medical support to the military and VA health care systems during an overseas conventional conflict, and to promote development of community-based disaster medical systems. The availability of beds in over 2,000 civilian hospitals is coordinated by VA and DoD Federal Coordinating Centers. The NDMS medical response component is comprised of over 7,000 private sector medical and support personnel organized into approximately 70 Disaster Medical Assistance Teams, Disaster Mortuary Operational Response Teams, and speciality teams across the Nation.

DISASTER RESPONSE TEAMS

Our primary response capability is organized in teams such as Disaster Medical Assistance Teams (DMATs), specialty medical teams (such as those that would provide burn and pediatric care), and Disaster Mortuary Teams (DMORTs). Our 27 level-1 DMATs can be federalized and ready to deploy within hours and can be self-sufficient on the scene for 72 hours. This means that they carry their own water, portable generators, pharmaceuticals and medical supplies, cots, tents, communications and other mission-essential equipment. These teams have been sent to many areas in the aftermath of disasters in support of FEMA-coordinated relief activities. In addition, staff from OEP and our regional emergency coordinators also go to the disaster sites to manage the team activities and ensure that they can operate effectively.

OEP's National Medical Response Teams (NMRTs) can provide medical treatment after a chemical or biological terrorist event. Each one is fully deployable to incident sites anywhere in the country with a cache of specialized pharmaceuticals to treat up to 5,000 victims of chemical exposures. The teams have specialized personal protective equipment, detection devices and patient decontamination capability.

Our mortuary teams can assist local medical examiner offices during disasters, or in the aftermath of airline and other transportation accidents, when called in by the National Transportation Safety Board and the Federal Bureau of Investigation.

In the last few years, OEP has deployed to New York, Florida, Texas, Louisiana, Alabama, Mississippi, the Virgin Islands and Puerto Rico in the aftermath of hurricanes and tropical storms. Our mortuary teams and management support teams have deployed to Rhode Island, Pennsylvania and California to assist local coroner offices after airline crashes. And we have supported local and federal efforts during special events such as World Trade Organization meetings, NATO 50th Anniversary events, Democratic and Republican National Conventions, Presidential inaugural events, and State of the Union Addresses in Washington, D.C. Most recently, OEP and NDMS have deployed to Texas to respond to the health and medical needs caused by Tropical Storm Allison, and to New York, Pennsylvania and Virginia in the aftermath of the horrors of September 11, 2001.

NDMS AGENCY PARTNERSHIPS

HHS, through OEP, manages and provides medical and mental health services, and mortuary services during disasters, and DoD has the lead responsibility for patient evacuation activities. DoD and VA share responsibility for definitive care activities, including managing a network of about 2,000 non-federal hospitals to ensure that hospital beds can be made available through a system of Federal Coordinating Centers (FCC). In addition, the VA provides other needed medical support during disasters. During the response to Tropical Storm Allison, the VA provided additional staffing to our Emergency Operations Center, dozens of additional medical and nursing personnel at the scene, and opened its VA hospital in Houston to receive patients when a majority of the hospitals in the Houston area were flooded and not able to receive patients. Currently, the VA is actively involved with us in New York City and in Washington, D.C. They have provided staff for our ESF #8 EOC, area managers to assist our Management Support Team in New York, mental health experts and crisis counselors, and nurses to treat burn patients both in New York and Washington.

The VA is partnering with OEP on other activities as well. The VA is one of the largest purchasers of pharmaceuticals and medical supplies. Capitalizing on this buying power, OEP and VA have entered into an agreement under which the VA manages and stores the four National Medical Response Team specialized pharmaceutical caches. The VA has purchased all of the pharmaceuticals and supplies, rotates the stock, maintains the inventory, ensures the security of the caches and ensures that the caches are ready for deployment. Additionally, during FY 2001, OEP provided funds to the VA to begin to develop plans and curricula to train NDMS hospital personnel to respond to WMD events.

OTHER OEP ACTIVITIES

OEP is working on a number of fronts to assist local areas hospitals, and medical practitioners to effectively deal with the effects of terrorist acts. HHS is taking the necessary steps to prepare our Nation for the health effects of terrorism, recognizing that should a chemical, nuclear, or bombing terrorist event occur, our cities and local metropolitan areas would bear the brunt of coping with its effects. In addition, we realized that the local medical communities would be faced with severe problems, including overload of hospital emergency rooms, medical personnel injured while responding, and potential contamination of emergency rooms or entire hospitals. Consequently, in FY 1995, HHS began developing the first prototype Metropolitan Medical Response System (MMRS). These systems, managed by local governments, are capable of providing triage and patient decontamination, population-based pharmaceutical prophylaxis and necessary medical care. In fact, the health care capacity issues that they are addressing are important regardless of the cause of mass casualties—for example, earthquakes, disease pandemics or terrorist events. To date, OEP has contracted with 97 of the Nation's largest metropolitan areas for MMRS development, and plans to initiate an additional 25 contracts during this fiscal year.

In FY 1999, Congress appropriated funds for OEP to renovate and modernize the Noble Army Hospital at Ft. McClellan, AL, in order for the hospital to be used to train doctors, nurses, paramedics and emergency medical technicians to recognize and treat patients with chemical exposures. The Noble Training Center is working with universities, medical centers, and other federal agencies to train medical practitioners, emergency room staff, hospital administrators, medical first responders, and others to ensure that our citizens receive the best possible medical care after a WMD event. Working with CDC and the VA, a training program was developed for pharmacists working with distribution of the National Pharmaceutical Stockpile.

CONCLUSION

The Department of Health and Human Services is committed to ensuring the health and medical care of our citizens. We are prepared to mobilize quickly the health care professionals required to respond to a disaster anywhere in the U.S. and its territories and to assist local medical response systems in dealing with extraordinary situations, including meeting the unique challenge of responding to the health and medical effects of terrorism. The Departments of Veterans Affairs and Defense are critical partners in these efforts.

Mr. Chairman, that concludes my prepared remarks. I would be pleased to answer any questions you may have.

Chairman ROCKEFELLER. Let us go on to Dr. Chu.

STATEMENT OF DAVID CHU, PH.D., UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS

Mr. CHU. Thank you, Mr. Chairman, Senator Specter, and members of the committee. It is a great pleasure to be here to represent the Department of Defense and to testify regarding the Department of Defense's view of VA support.

As you know, the 1982 legislation authorized the VA to serve as the principal health care backup to the Department of Defense in the event of war or national emergency that involves armed conflict. The Department of Defense operates its own medical care system, the military health system, which consists of just under 80 hospitals and several hundred clinics worldwide and serves a population of just over eight million people.

Because this is a deployable system, we do have a significant number of capabilities that allow us to respond in a mobile mode to contingencies such as occurred in New York, and I am proud to report that we did play a small role. As you are probably aware, the hospital ship Comfort deployed in New York within 48 hours of the disaster under the direction, I should emphasize, of the Health and Human Services leadership. And indeed, of course, the

Army's Delorenzo clinic at the Pentagon, in addition to teams from Walter Reed, were some of the first responders to the attack on the Pentagon itself.

The 1982 law led, as this committee is aware, to the establishment of the VA/DoD Contingency Hospital System, which is codified in a memorandum of understanding between the two cabinet departments. That system is activated by the Secretary of Defense after he or she determines that we need VA's help and so notifies the Secretary of Veterans Affairs, who in turn commits the VA resources.

Within the United States for military medical operations, the Commander in Chief of the United States Joint Forces Command is in charge and develops an integrated medical operations plan for the continental United States, and, of course, the VA and DoD contingency hospital system supports that plan.

The VA/DoD system is supplemented by what Secretary Allen described, and that, of course, is the National Disaster Medical System, which he has outlined here. I think the success of the joint venture was demonstrated in the aftermath of September 11. The Secretary of HHS did activate the National Disaster Medical System and both VA and DoD began reporting, as they were required to do, with their bed availability to what is called the Global Patient Movement Requirement Center, located at Scott Air Force Base. Again, as Secretary Principi testified, tragically, there was not a significant number of casualties to care for. But I do think the events of September 11 highlighted the importance of a coordinated Federal response to national disaster.

You asked, Mr. Chairman, in your letter of invitation that I address also the issue of medical record keeping for our military forces, which was, to put it as politely as possible, problematic during the Gulf War and suffered from some of the defects that you and your committee have identified. I am pleased to report that the Department of Defense has made significant progress since that date in trying to rectify those deficiencies.

We have now a new set of direct instructions that outline the kind of records that must be kept and the medical surveillance that must be maintained. We have both a pre-deployment health assessment that is to be completed and a post-deployment assessment to which it is to be matched. I took the step just within the last 2 weeks of reminding all elements of the Department of the requirement to report on the units to which each individual is attached, both the unit to which the individual is attached for administrative purposes as well as the unit to which he or she is attached in terms of actual operations in the field.

Over the longer term, we are looking to the second version of the Composite Health Care Systems, known as CHCS II in bureaucratese, to give us the kind of computer-based record that could be accessed from around the world within the context of what we call a Theater Medical Information Program for the kind of record that I think you are aiming for as the standard we should——

Chairman ROCKEFELLER. Which will not be ready until 2003, am I right?

Mr. CHU. The CHCS II operational test will take place just about 1 year from now, so yes, it will be a couple of years before we have this widespread. But I should emphasize that this is a long-term program. It is not something we can do overnight. It is important, I would emphasize, in terms of clinician acceptance, on which its excellence and data accuracy depend to get this right so the clinicians will actually use it and put the information in that we need.

In conclusion, sir, I simply want to emphasize that the collaborative efforts between the Veterans Administration and the Department of Defense continue on a daily basis. The excellent relations among our personnel and our relationship also with HHS, I think, give us great confidence that VA will be there to help DoD when we need it and that we will both function well within the larger system as far as the domestic United States is concerned for which HHS is responsible. Thank you.

Chairman ROCKEFELLER. Dr. Chu, I know you have other appointments and I do not want you to keep them——

[Laughter.]

Chairman ROCKEFELLER [continuing]. Because I have some questions for you, but if you have to, you have to and we understand.

Mr. CHU. I am good for a little while longer, sir. Thank you.

Chairman ROCKEFELLER. OK.

[The prepared statement of Mr. Chu follows:]

PREPARED STATEMENT OF DAVID CHU, PH.D., UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS

INTRODUCTION

Mr. Chairman, I am pleased to be invited here today to present to you and the members of the Committee the Department of Defense's views on the Department of Veterans Affairs' (VA's) role as principal backup to the Department of Defense in the event of war or national emergency. The Department of Defense places enormous value on all of its sharing partnerships with the Department of Veterans Affairs. Since the outset of the sharing program which was established under the 1982 legislation, "Department of Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act (38 USC 811(f)), DoD has subscribed to the promise for improved economies of operation that health resources sharing has held.

VA AS BACKUP TO DOD IN WAR OR NATIONAL EMERGENCY

In addition to promoting greater peacetime sharing of health care resources between VA and DoD, this vital legislation authorized the VA to serve as the principal health care backup to DoD in the event of war or national emergency that involves armed conflict. The Military Health System (MHS) consists of 78 hospitals and more than 500 clinics worldwide serving an eligible population of 8.3 million. In addition, we have medical units capable of deploying with our Armed Forces to provide the preventive and resuscitative care that our troops may require while serving outside the United States. We emphasize the prevention of injury and illness. We identify hazardous exposures, and record immunizations and health encounters in a computerized fashion for patient safety and any needed patient care events. We deliver the healthcare benefit as defined by the Congress and ensure high quality healthcare to all eligible beneficiaries in all scenarios. The Military Health System relies on fully trained and militarily prepared healthcare personnel. Our primary responsibility is to provide medical support for our deployed forces, and those capabilities are inextricably linked to our hospital and clinic operations, A robust healthcare delivery system is our strategic lynchpin to ensure that our force is healthy and that our medics are prepared to deliver medical support in contingencies.

Because of our constant vigilance and need to be prepared to support the Armed Forces in any location around the world, military medicine has a tremendous ability to provide health and medical capabilities rapidly in a mobile or deployed mode. Some of these capabilities include field hospitals, specialized medical augmentation

teams, field laboratory diagnostic capabilities, medical evacuation, public health, vector control, patient tracking, veterinary support, medical supply support, and mass casualty care. Additionally, we have our stationary military medical treatment facilities located around the nation that have inpatient capabilities.

The military health system continues to leverage the wartime capabilities of the men and women in our armed forces for domestic consequence management in support of the civil authorities. I am very proud of the efforts of our military medical team in response to the events of September 11th. The hospital ship USNS Comfort was dispatched within 48 hours to New York City with Navy medical personnel from the National Naval Medical Center. The Army's Delorenzo clinic staff at the Pentagon was among the first responders to the attack on the Pentagon. Additionally, Walter Reed Army Medical Center immediately dispatched three trauma teams, a preventive medicine team and two combat stress teams to respond to the Pentagon crisis.

In response to the 1982 law authorizing a new contingency role for the VA, a Memorandum of Understanding (MOU) was executed between the Secretary of Defense and the Administrator of Veterans Affairs (presently the Secretary of Veterans Affairs), specifying each agency's responsibilities under the law. Plans have been developed and are jointly reviewed and updated every year by VA and DoD. The VA/DoD Contingency Hospital System is outlined in the Veterans Health Administration Handbook 0320.1 of May 1, 1997.

The VA/DoD Contingency Hospital System is activated by the VA after the Secretary of Defense determines that DoD needs VA medical care resources because of a military conflict or another type of national emergency. The Secretary of Defense notifies the Secretary of Veterans Affairs, in writing, of any need for medical care contingency support. The Secretary of Veterans Affairs commits VA to provide support and communicates this commitment to the Secretary of Defense in writing. Through the VA/DoD Contingency Hospital System, DoD receives periodic estimates of VA contingency bed availability.

The Commander-in-Chief (CINC), US Joint Forces Command (JTFCOM) has overall responsibility to ensure integrated CONUS medical operations. Consequently, CINC JTFCOM has in place the Integrated CONUS Medical Operations Plan (ICMOP) that coordinates all CONUS medical assets in support of DoD casualties. ICMOP is supported by the VA/DoD Contingency Hospital System Plan.

One important objective of the overall planning effort is to assess VA's contingency bed capacity. Accordingly, VA medical centers assess 13 specific bed categories (that include highly specialized beds) required by DoD. These assessments take into account the impact on local operations of VA employees subject to mobilization, since long-standing VA policy is that no employee is unavailable for active military duty in a national emergency by reason of his/her position or assignment.

The VA and DoD bed contingency plans are also supplemented by the National Disaster Medical System. This robust bed expansion capability will be activated subsequent to a war or national emergency requiring more than the combined resources of the DoD and VA. This joint Federal, State, and local mutual assistance organization provides for a coordinated medical response in time of war, national emergency, or major domestic disaster resulting in a mass casualty situation. Patients are evacuated to designated locations throughout the United States for care that cannot be provided locally. They are placed in a national network of hospitals that have agreed to accept patients in the event of a major disaster. DoD is a primary Federal agency responsible for administering the NDMS. Other agencies sharing responsibilities with DoD include the Department of Health and Human Services (DHHS), FEMA, and the VA. NDMS may be activated by the Assistant Secretary of Defense for Health Affairs in support of military contingencies when casualties exceed the combined capabilities of the VA/DoD Contingency Care System. The Assistant Secretary of Health (DHHS) may activate NDMS in response to a domestic conventional disaster. Under the latter circumstances, DoD components, when authorized, will participate in relief operations to the extent compatible with U.S. national security interests.

The success of this joint venture was aptly demonstrated immediately following the September 11th attack on the World Trade Center Towers and the Pentagon. In anticipation of receiving casualties, The Secretary of Health and Human Services activated NDMS whereupon both VA and DoD began to report bed availability to the Global Patient Movement Requirements Center (GPMRC) located at Scott Air Force Base, Illinois. There were however no casualties evacuated as a result of this tragedy, as local resources were able to handle health care requirements.

The events of September 11th have highlighted the importance of a coordinated federal response to national disasters. While each of us must ensure that our health care system is capable of meeting the demands of our respective missions, we recog-

nize the vital role the Department of Veterans Affairs plays in providing backup to the Department of Defense in the event of war or national emergency.

MEDICAL RECORD KEEPING

Mr. Chairman, you asked that we address our efforts to improve medical record keeping in light of the lessons learned from the Gulf War and subsequent deployments. As you know, record keeping during the Gulf War was problematic: immunizations were not always recorded, documentation of healthcare provided to service members was not always locatable following the war, record keeping policies were not standardized, and automated systems were not fully implemented.

I am pleased to report that we have made significant progress. We have published directives and instructions and issued policies on record keeping and medical surveillance during deployments, we continue to develop and improve automated record keeping systems, and we continue to work with the VA to facilitate transfer of medical records for our veterans and retirees.

Specifically, we are leveraging advances in technology to improve our medical records. We have two automated systems that when combined will form the longitudinal view of health information that captures health encounters for every service member. These two systems are the Composite Health Care System II (CHCS II), also referred to as the military computer-based patient record, and the Theater Medical Information Program. Our collaboration with the VA on information systems will allow these computer-based patient records to be available to the VA should the contingency system be activated.

NATIONAL CENTER FOR MILITARY HEALTH AND DEPLOYMENT READINESS

Finally, Mr. Chairman, I would like to address the efforts to establish a National Center for Military Health and Deployment Readiness. As you know, our role in this effort was to respond to the Institute of Medicine recommendations through a joint report with the VA. With the VA, we concurred with the two recommendations and the report was submitted to Congress. The VA has taken action to achieve both recommendations. In May of this year, VA announced establishment of two new Centers for the Study of War-Related Illnesses, one at the East Orange, New Jersey, VA Medical Center, and the other at the Washington, D.C. VA Medical Center. For the second recommendation, the VA with support from DoD and the Department of Health and Human Services, proposed that the best approach for the National Center concept would be through the Military and Veterans Health Coordinating Board. Further, the Research Working Group of the Coordinating Board would function as the National Center's operating unit. This approach has been working since the September 2000 joint report.

I would like to apprise you of a related effort underway in DoD. The National Defense Authorization Act of 1999 authorized the Secretary of Defense to establish centers for the study of post-deployment health concerns. in September of 1999, the Assistant Secretary of Defense for Health Affairs established the Centers for Deployment Health. These Centers comprise a research center at the Naval Health Research Center in San Diego, CA, a clinical center at Walter Reed Army Medical Center in Washington, D.C., and a Defense Medical Surveillance System at the Army's Center for Health Promotion and Preventive Medicine. Examples of the work being conducted at these centers include the Millennium Cohort Study. This is a cross-sectional sample of 100,000 U.S. military personnel who will be followed prospectively, as an integral part of the Department's strategy to preclude Gulf War Illnesses-type experiences in future deployments and to maintain troop morale, confidence, and effectiveness. At the clinical center, we have developed a Clinical Practice Guideline for Post-Deployment Health Evaluation and Management. This guideline will allow transition from diagnosis-driven treatment to a program of clinical care for post-deployment health concerns managed in the primary care setting. The guideline emphasizes the patient and provider relationship and offers historical context for the provider, which is a dynamic information source necessary to establish a credible patient relationship and appropriately assess the patient's post-deployment health concerns. This guideline represents the promised improvement in treatment of our patients with deployment-related health concerns. The Defense Medical Surveillance System is a comprehensive, longitudinal, relational, epidemiological database where all theater medical surveillance and treatment data will be captured and stored.

The goal of these Centers is to improve our ability to identify, treat and minimize or eliminate the short- and long-term adverse effects of military service on the physical and mental health of our service members and veterans.

Mr. Chairman, in summary, let me say that the collaborative efforts between VA and DoD continue daily. Because of the resulting relationships among our personnel, we have tremendous confidence that should the day dawn when we need to call on the VA to help us care for our casualties, they will be ready.

Chairman ROCKEFELLER. Yes, Mr. Baughman?

STATEMENT OF BRUCE P. BAUGHMAN, DIRECTOR, PLANNING AND READINESS DIVISION, READINESS, RESPONSE, AND RECOVERY DIRECTORATE, FEDERAL EMERGENCY MANAGEMENT AGENCY

Mr. BAUGHMAN. Good afternoon, Mr. Chairman, members of the subcommittee. It is my pleasure to represent Director Allbaugh at this hearing on the role of the Department of Veterans' Affairs in emergency response. My remarks will be brief. I will describe how FEMA works with other agencies under the Federal Response Plan framework and where the Department of Veterans' Affairs fits into that framework.

FEMA's mission is to reduce the loss of life and property and to protect the nation's critical infrastructures from all hazards. However, we are a relatively small agency. We do not own all the resources needed to respond to a disaster. Our success depends on our ability to organize and lead a community of local, State, and Federal agencies and volunteer organizations in responding to disasters. While we promote the ability of voluntary organizations, local governments, and States to manage the vast majority of emergencies in this country on their own, we do realize that from time to time, they are overwhelmed. When that happens, under the Stafford Act, we can provide a management framework and a funding source to marshal Federal resources in support of State and local government.

The heart of our response framework is the Federal Response Plan. The Federal Response Plan reflects the work of an interagency planning group that meets in Washington and all 10 of our FEMA regions. It develops the Federal Government's capability to respond as a team. This team includes 26 Federal departments and agencies and the American Red Cross, all of which are signatory to the plan.

The plan organizes departments and agencies into 12 emergency support functions, based upon the authorities and expertise of the members and the needs of their counterparts at the State and local government level. Each of these emergency support functions have a primary agency. The primary agency is the agency with the most authority and expertise in that particular area and supporting agencies are agencies that can provide additional relevant capabilities.

Since 1992, the Federal Response Plan framework has proven to be effective time and again for managing major disasters in emergency regardless of cause, including the recent terrorist attacks in New York and at the Pentagon. FEMA's principal role under the Federal Response Plan is to manage the allocation of Federal resources to assist State and local governments where there is a valid need. We try and find the right resource and provide it at the right time and in the right place.

The Federal Government is not always the best resource to meet the requirement. When it is, a department or agency may be able to provide that needed resource under its own authority with its own resources. If not, then FEMA issues a mission assignment that provides for reimbursement of costs associated with the mission. If the mission falls within the scope of the emergency support function, FEMA assigns it to a primary agency for that function. The primary agency then may sub-task that to another supporting agency.

Since FEMA's concern is resource allocation, we want to have as large a pool as possible to address each one of these critical functional areas. The Department of Veterans' Affairs has substantial assets, including medical facilities, medical staff, and pharmaceuticals, and we are pleased to count them among the signatories to the Federal Response Plan.

Within the Federal Response Plan framework, VA is a supporting agency under the Emergency Support Function No. 8, "Health and Medical." The Department of Health and Human Services is the primary agency for ESF No. 8 and would sub-task VA for medical missions as appropriate, and I defer to both other organizations to discuss the good work that they have provided under that Emergency Support Function and under the National Medical Response System.

I should also mention that VA is also a supporting agency to the U.S. Army Corps of Engineers under our Emergency Support Function No. 3, "Public Works and Engineering," the American Red Cross under "Mass Care," Emergency Support Function No. 6, and the General Services Administration under Emergency Support Function No. 7, "Resource Support."

Mr. Chairman, that concludes my remarks. I look forward to any questions at this time.

Chairman ROCKEFELLER. Thank you.

[The prepared statement of Mr. Baughman follows:]

PREPARED STATEMENT OF BRUCE P. BAUGHMAN, DIRECTOR, PLANNING AND READINESS DIVISION, READINESS, RESPONSE, AND RECOVERY DIRECTORATE, FEDERAL EMERGENCY MANAGEMENT AGENCY

INTRODUCTION

Good morning, Mr. Chairman and Members of the Subcommittee. I am Bruce Baughman, Director of the Planning and Readiness Division, Readiness, Response, and Recovery Directorate, of the Federal Emergency Management Agency (FEMA). Director Allbaugh regrets that he is unable to be here with you today. It is a pleasure for me to represent him at this hearing on the role of the Department of Veterans Affairs in emergency response. My remarks will be brief. I will describe how FEMA works with other agencies under the Federal Response Plan framework and where the Department of Veterans Affairs—the VA—fits within that framework.

FEMA AND THE FEDERAL RESPONSE PLAN COMMUNITY

The FEMA mission is to reduce the loss of life and property and protect our nation's critical infrastructure from all types of hazards. However, we are a relatively small agency; we do not "own" all the resources needed to fulfill that mission. Our success depends on our ability to organize and lead a community of local, State, and Federal agencies and volunteer organizations. We promote the ability of individuals, families, businesses, voluntary organizations, local governments, and States to manage the vast majority of emergencies in this country on their own. Under the auspices of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, we also provide a management framework and funding to bring the Federal Government's resources to bear when State and local governments need help with emer-

gency or disaster situations, or when these situations involve a primarily Federal responsibility.

The heart of our response framework is the Federal Response Plan. The Federal Response Plan reflects the labors of interagency planning and coordination groups that meet as required in Washington and all ten FEMA Regions to develop our capabilities to respond as a team. This team includes 26 Federal departments and agencies and the American Red Cross, all signatories to the plan. The plan organizes departments and agencies into interagency functions based on the authorities and expertise of the members and the needs of our counterparts at the State and local level.

Currently, there are 12 of these "Emergency Support Functions": Transportation, Communications, Public Works and Engineering, Firefighting, Information and Planning, Mass Care, Resource Support, Health and Medical Services, Urban Search and Rescue, Hazardous Materials, Food, and Energy. Each has a primary agency—the agency with the most authority and expertise in that area—and supporting agencies that can provide additional relevant capabilities.

Since 1992, this Federal Response Plan framework has proven effective time and time again, for managing major disasters and emergencies regardless of cause—including the recent terrorist attacks.

FEMA's principal role under the Federal Response Plan is to manage the allocation of Federal resources to assist State and local governments. Where there is a valid need, we try to find the best way to provide the right resource to the right place at the right time. The Federal Government is not always the best source—there may be resources available commercially in the area or from a neighboring State government. When the Federal Government is the best source, a department or agency may be able to provide what is needed under its own authority and with its own resources. If not, FEMA issues a mission assignment and provides for reimbursing the costs associated with the mission. If a mission falls within the scope of an Emergency Support Function, FEMA assigns it to the primary agency for that function; the primary agency may then task its supporting agencies.

THE DEPARTMENT OF VETERANS AFFAIRS WITHIN THE FEDERAL RESPONSE PLAN FRAMEWORK

Since FEMA's concern is resource allocation, we want to have as large a pool of available resources as we can. We recognize that as one of the nation's largest healthcare providers, the Department of Veterans Affairs has substantial assets—including medical facilities, medical staff, and pharmaceuticals—and we are pleased to count the VA among the signatories to the Federal Response Plan. Within the Federal Response Plan framework, VA is a supporting agency under ESF #8, Health and Medical Services. The Department of Health and Human Services is the primary agency for ESF #8, and would subtask VA for health and medical missions as appropriate. I defer to both organizations to discuss their work under ESF #8 and the National Disaster Medical System in more detail.

I should note that VA's role in the Federal Response Plan does not end there. VA is also a supporting agency to the U.S. Army Corps of Engineers under ESF #3, Public Works and Engineering, committed to making its facilities engineering personnel available if needed. VA is a supporting agency to the American Red Cross under ESF #6, Mass Care, to provide medical supplies, food preparation, and facilities if needed to support shelter operations. VA can support the General Services Administration under ESF #7, Resource Support, with procurement and distribution, including technical assistance on procuring medical supplies and services. VA has made a commitment to supporting Federal Response Plan operations in whatever way they can, and we at FEMA appreciate it.

CONCLUSION

Mr. Chairman, that concludes my remarks. I would be pleased to answer any questions you or the Committee may have.

Chairman ROCKEFELLER. Mr. Allen, I could tell, as I think you could, that there was not a total sense on the part of Secretary Principi that he and the largest health care agency in the Nation were really at the table insofar as HHS is concerned. Now, I have expressed my high belief in Secretary Thompson. He just addressed our Democratic Caucus, where he got a standing ovation. I mean, he is absolutely first rate. That is immaterial to the fact that HHS seems to have difficulty in consulting with VA on matters that

have happened since September 11 or which might happen in the future, and the ongoing emergency preparedness situation, and I would just appreciate your response to that.

Mr. ALLEN. Certainly. Since September 11—in fact, prior to September 11—at my level, the deputies' level, we have been working with—I have worked with the deputy at VA to address these very issues. So there were issues that we were looking ongoingly at with regard to the relationship that the Veterans Administration has with HHS, not only in the area of emergency preparedness, but also, for instance, homelessness. We had scheduled a series of meetings prior to September 11 to begin focusing on these very issues. September 11 just brought home the importance of that coordination at the highest levels between our departments.

In fact, even as VA was organizing its Domestic Emergency Response Teams, they had requested for us to participate with them in that and I agreed to do so on behalf of our Department. So while I can understand the concerns of what that relationship might have been prior to September 11, I want to assure you that Secretary Thompson had already given the directive that we would be working much closer together in areas of terrorism and bioterrorism preparedness.

I guess that is the assurance I can give you, that we are working together. We have already scheduled a series of meetings to look at terrorism, look at domestic response to emergency issues, as well as other issues that we share common interest in, including homelessness, for example.

Chairman ROCKEFELLER. I was at a Federal agency yesterday for most of the day looking at it carefully, and there was great frustration expressed by that agency toward another Federal Government agency about an extremely important project which they were both doing but in which they refused to share information. I was stunned. I was stunned. These are very, very important agencies.

I am getting at bureaucratic behavior here, and I want your honest answer because I want to know how often you talk—not the Secretaries, but you and the relevant people, HHS people, VA people. It came down to the fact that the director of one of these agencies, the head of one of these agencies was absolutely for the cooperation but was completely undermined by those who had been there longer than he had at the operating levels. Therefore, there was absolutely no contact on something which was in the national interest. It is that kind of behavior which is so disturbing to me and which I want you to put me at ease about.

Mr. ALLEN. Sure. My role in the Department as the Chief Operating Officer is to break through those very issues that you describe and I can describe them within our Department itself, those types of issues that come up where you have fiefdom protection in that sense, and so I understand what you are saying.

I guess my assurance to you is that in my capacity as the Deputy Secretary, my role is to break down those barriers, to make sure that the type of communication, the type of coordination that allowed us to respond to September 11, that allow us to respond to events here, must be ongoing. This is not something that is done once. It is something that has to be done continuously. We need to

coordinate. We need to train together. We need to cooperate together.

I have been in numerous meetings since September 11 where we would share many frustrations that you described. But I believe that the President has made it very clear to us that he expects us to work well together. He expects us to set aside petty differences and try to resolve the issues that are confronting us together.

And I want to try to assure you that that is happening. If there is an issue that I have a concern with involving another agency or department, I go to the deputy of that department and share that concern with them and I get a response. That is the type of relationship that we are trying to develop within the executive branch, that we respond to the concerns of each other to try to address common problems.

Chairman ROCKEFELLER. There are two types of communication. One is when something goes wrong or when there's a need for something to happen, and then people call because they have to. The other kind—and, granted, this is not a fair test post-September 11 when everything has been urgent—is when there is not an immediate response needed but people contact each other because they are in the business of staying in communication in the eventuality that that communication will flourish into trust and a good working relationship later.

Since September 11, you have been in touch with what kind of regularity with the VA? Prior to September 11, what was the situation? And I do not hold you accountable to this.

Mr. ALLEN. No, and I appreciate that.

Chairman ROCKEFELLER. We are all Federal people. We all do silly and smart things.

Mr. ALLEN. Certainly. Prior to September 11, and that is what I want to emphasize to you. I think much of the coordination and the relationships that had been built among the departments started prior to September 11, and that was in large part because of the leadership of Secretary Thompson, who——

Chairman ROCKEFELLER. You have already said that. What I was asking for is a breakdown pre-September 11 and post-September 11, the number of contacts, what drives those contacts.

Mr. ALLEN. I would be more than happy to provide you—I cannot tell you what has happened down in the——

Chairman ROCKEFELLER. Give me a sense.

Mr. ALLEN [continuing]. But I know that our Office of Emergency Preparedness works regularly with the VA, with FEMA, with DoD. Dr. Chu and I had discussions prior to September 11 about issues related to stockpile issues. I have had personal conversations and involvement with Leo McKay, the deputy at VA, on a regular basis on issues of commonality, of common interest, including bioterrorism and terrorism preparedness.

And so I cannot quantify it. I would be glad to go back and try to accomplish that for you, how our departments are working together. But I guess what I am trying to give you is an assurance that that has happened. It has happened before September 11, and clearly, it is happening post-September 11.

Chairman ROCKEFELLER. OK. I am going to finish. Excuse me, Senator Specter. Again, I go back to the 1998 law, and I am sorry,

I just have to pick on this because I am fixed on it, not on it but on the general subject.

The National Center for Military Health and Deployment Readiness, this is all about chemical, biological, and other types of battlefield exposures. We passed a law to have VA, DoD, HHS work together in something called the National Center for Military Health and Deployment Readiness. It is a fact, however, that the governing board which was created by that has never convened.

Now, nobody knew September 11 was coming. Oh, yes, we did. Oh, yes, we did. We all knew it was coming. It was just a question of how and in what form and we were very surprised by its form. We were not ready for that. It is that kind of behavior that I am getting at, and I am not picking on you, I do not mean anything of that sort, I am just trying to drive the point home that the rules all changed, it seems to me, now, and for good.

Mr. ALLEN. Point well taken. I do not know the specifics about the meetings of the board, but I can tell you what our Department has been doing in conjunction with the National Center for Military Health. CDC has been integrally involved in working with——

Chairman ROCKEFELLER. Do you know what? I do not really want to know what CDC has been doing. I want to know why the board has never met——

Mr. ALLEN. I do not have an answer——

Chairman ROCKEFELLER. I will just give you the piece of paper and then you can get back to me.

Mr. ALLEN. I will be glad to do that.

Chairman ROCKEFELLER. OK. And nothing personal, I promise you.

Mr. CHU. If I could add, Senator——

Chairman ROCKEFELLER. Yes?

Mr. CHU [continuing]. The implication is that the three departments have not done anything on this. It is my understanding that, indeed, responsive to the Institute of Medicine report on the subject, that VA has stood up two centers, one in Washington and one in East Orange, if I recall correctly, and determined that in terms of some of the issues that the so-called research working group that grew out of the Gulf War illness effort ought to be the agent for coordinating research among the agencies and ensuring that the right kind of subjects are pursued.

I should indicate that, as you may be aware, the Armed Services Committees also mandated in a law the following year that DoD take certain actions and we have stood up within the Department of Defense a series of Centers for Deployment Health, one building on the Navy center in San Diego, one building on converting capabilities at Walter Reed, and further, a third, a medical surveillance system.

So there has been significant action. Being a new appointee, I do not know whether this board has ever met or not, but there has been significant action by the departments involved on the agenda that the law mandated.

Mr. ALLEN. And I think it is important to note—I am not sure where this comes from, but I believe the VA is responsible for convening the board, so I do not think that at HHS, we are appro-

priate to answer that question—why. I just simply say that there is work that has been ongoing——

Chairman ROCKEFELLER. Let us put that one aside and figure we are going to get the answer to it.

Dr. Chu, you referred to it yourself, and that is the—as you delicately said—the problem with recordkeeping in the Gulf War. Those were some days, pyridostigmine bromide and the whole history surrounding that. And the problem there, when you look at it, was with massed forces. Here, we are potentially talking about fewer forces, more control, certainly medical people with smaller groups, whether they be 4 or 400.

Keeping medical records is just not miscellaneous talk but tremendously important for everything that happens. That did not work that well in the Gulf War. There continued to be a lot of concerns during Joint Endeavor in Bosnia, and I would like to get a sense of what happened there—there had been new medical surveillance policies, as you indicated, they had been put in place, but there were still problems.

What is going on now? You have described the high-tech part, but what is going on now. I'm not referring to post-September 11, but what is the procedure now for making sure that if somebody takes a pill, it is recorded, and particularly that it has to be signed in, all that kind of thing?

Mr. CHU. Let me deal with what I think is the most important issue and that is providing a baseline of people's health status before they deploy and being able to compare that with their post-deployment situation, and we now have in place, which we did not have, unfortunately, in the Gulf War period, a requirement that such an assessment be conducted and that such a post-deployment assessment be carried out.

The second—and we actually have—the Department has taken action using the 10th Mountain Division as a test case to look at what they actually did to be sure that it complies with policy, because one of the issues in a bureaucracy is you might announce that this is the policy, but the question always is are people carrying it out faithfully.

The second critical issue is or was and remains being able to track exactly where people are during a deployment and to what they might have been exposed during that period of time, and as I indicated, the Department, about a year and a half ago, published a very thick directive that spelled all this out. I reminded everybody within the last couple of weeks that your first data submission was due on October 11 showing all deployments since September 11, which does include each person by name, the unit to which they are administratively assigned, as well as the unit which they are actually deployed with.

The further challenge, which we are energetically working on, is to make sure we can keep track of where all those units are over time so that the information can be put together. Some of that will have to be dealt with at the classified level as a practical matter, and there are certainly administrative issues to be overcome in carrying that out.

So while I do not want to pretend it is perfect or that everyone is doing exactly as he or she has been told to do, we are checking

on whether or not they are doing as they are supposed to be doing and I am hopeful that we will have a much better situation this time around than we did the last time.

Chairman ROCKEFELLER. Thank you, sir.

Senator Specter?

Senator SPECTER. Mr. Chairman, I would like the record to show that you have a very loyal staff. After a while, I asked them to put the red light on and they declined. [Laughter.]

So I asked them to put the yellow light on and they refused to do that. Then I asked them to put the green light on and they would not put any light on. [Laughter.]

May the record show that the chairman and I have a very good relationship and I joshed him just a little in saying that he was longer-winded when he was ranking member, but we work well together and these time limits are a little bit arbitrary.

Mr. Allen, I want to pick up on one comment you made which is not too important in the exact language you used but it reflects, perhaps, an attitude and it is worth emphasizing. You said that you cannot have any more petty disputes between agencies. You should never have petty disputes. Now is the time to have all the disputes resolved. You have really got to get it done and find the answer.

I think Senator Rockefeller pushed you exactly properly for the convening of the board. It is an answer, but not a very good answer, to say that it was the VA's job to convene the board, because HHS knew that VA had not convened the board. So there is a responsibility everywhere to get the board convened and that is the point that Senator Rockefeller made, that when Congress enacts this kind of legislation, it ought to be followed. There are enough disputes between the executive and legislative branches without simply disregarding a requirement like that.

You talk, Mr. Allen, about $1.5 billion to take care of your needs, and Senator Byrd and Senator Stevens and Senator Harkin and I wrote a letter to the President asking him for specifics as to what he wanted done after we heard Secretary Thompson. I believe the incentives to put that additional appropriation into the $40 billion of the last $20 billion, which has already been authorized, but is there a sense of urgency in your Department that it ought to be included in the appropriations bill which has just been reported by the committee to the full Senate? Or can you wait until they divide up $40 billion or the last $20 billion of that which has already been authorized?

Mr. ALLEN. Senator Specter, we have already received some funds out of the first $20 billion that has been authorized to augment the stockpile.

Senator SPECTER. How much have you gotten?

Mr. ALLEN. I believe it was—and I can get the actual figure—I believe it was $51 million that we needed to increase our existing stockpiles and——

Senator SPECTER. So is the availability of that money adequate to meet your needs right now? Do you not need to have it included in the regular fiscal year 2002 appropriations bill?

Mr. ALLEN. I do not have an answer for you right now on that because the meeting I am going to next is going to address that. We are working very closely with the interested——

Senator SPECTER. If you do not have an answer right now, let us have an answer by tomorrow——

Mr. ALLEN. Certainly.

Senator SPECTER [continuing]. Because the bill is going to the floor.

Mr. ALLEN. Certainly. We will be glad to do that.

Senator SPECTER. Have you visited the Centers for Disease Control?

Mr. ALLEN. Yes, I have.

Senator SPECTER. I visited CDC about 18 months ago after hearing tales of how deplorable it was with people—noted Ph.D.'s, et cetera—having their desks in halls. I could not believe the reports I had heard, so I went to see for myself, and I and saw the situation was even worse. How recently did you see it?

Mr. ALLEN. On September 13.

Senator SPECTER. Well, that is some action after the 11th. Have there been improvements? What is it like now?

Mr. ALLEN. I am not sure what the condition was when you visited. I would say, in many cases, the same. I think that we need to make critical investments in supporting the infrastructure there. We need to make critical investments——

Senator SPECTER. Turn my red light on, please. [Laughter.]

Mr. ALLEN. I believe I visited on much of the same tour.

Senator SPECTER. I want to be even-handed with the chairman, that is all. I want to make a request for my red light on.

Take a look at that.

Mr. ALLEN. Certainly.

Senator SPECTER. Senator Harkin and I have taken the lead and have added $250 million now, and that is on the way to over than a billion dollars for improvements. But let us know if you need more sooner or some of it ought to come out of the billions already put up because CDC is really very, very central.

And since my red light is on theoretically, I am going to conclude, Mr. Chu, but I want to italicize what Senator Rockefeller has said about the records. We have had a tremendous problem with Persian Gulf Syndrome and trying to find out what happened because the records have not been maintained. Notwithstanding the problems of the Gulf War, they were not maintained on Operation Joint Endeavor in Bosnia. So you really ought to get your Department on notice that they have had fair warning and that we on this committee heard so many veterans complain so bitterly about what is going on, that really ought to be rectified.

I have another hearing to attend—one with the Secretary of Treasury—so I am going to excuse myself, Mr. Chairman.

Chairman ROCKEFELLER. Let me conclude this by making a philosophical statement. Those are dangerous. I recognize the ease that we have as Senators to do oversight and how we get to ask all kinds of questions. September 11 is just a month and 4 or 5 days ago, and you are meant to know everything and have all the answers. It is not fair in some ways. However, oversight is built into the Constitution. It is a balance of powers. We have to struggle

mightily to have you understand that we are, in fact, on your side. But the only way that we can do that in that we are not in the executive branch—is to ask you the kinds of questions which at least in theory bind us together in a common pursuit of efficiency, expediency, results.

So sometimes we appear hostile—sometimes we are hostile. Sometimes it is meant to be nothing more than that, and that goes back to the Persian Gulf situation. But I just want to explain myself on that. We are all in this together and I really do mean that, and I do not mean these hearings to be about one side beating up on another. They are too often like that and I do not like it; I sometimes engage in it and I apologize.

I have one question for you, Mr. Baughman, just because I do not want you to feel lonely. [Laughter.]

It is sort of a hostile one, and that is: when we were referring to the interagency planning and FEMA's responsibility, you seemed to be a little bit saying that HHS and VA should get their act worked out. FEMA is part of the deal.

Mr. BAUGHMAN. Yes, FEMA is part of the deal, sir. We are the coordinating agency. We have appointed HHS and those other agencies as part of the health and medical function. Rather than us dealing independently with 26 agencies, we have got a lead agency and that is HHS. HHS has got to work with VA as to how they are going to access VA assets.

Now, what we have done from time to time where VA has come to us and said, look, we do not think that our assets are being fully engaged, we have sat down with HHS and VA and tried to work through those issues. But we have tried to work this system out so that the primary agency is fully engaging the support agencies, and in some of our functional areas, it works great. In this one, probably the relationship is not at its optimum and we will encourage them to sit down at the table again and work through these issues.

Chairman ROCKEFELLER. That is a fair enough answer.

I would like to insert into the record prepared testimony from Paul Hayden, Associate Director, National Legislative Service, Veterans of Foreign Wars of the United States, and Jaqueline Garrick, Deputy Director for Health Care, National Veterans' Affairs and Rehabilitation Commission of the American Legion.

[The information referred to follows:]

PREPARED STATEMENT OF PAUL A. HAYDEN, ASSOCIATE DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and members of the committee:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States (VFW) and its Ladies Auxiliary, I would like to thank you for the opportunity to make a statement on such an important and timely topic.

First, we would like to commend the Department of Veterans Affairs (VA) for its role in the response to the domestic terrorist acts that shocked our nation last month. According to the Office of Emergency Preparedness' (OEP) Situation Report #25, released on October 3, 2001, the VA "is providing support to the city [New York] through its VA health care facilities . . ." of which the "VAMC Manhattan received and treated a total of 76 victims with an additional 17 treated at the VAMC Brooklyn, three at the VAMC in the Bronx and two at the Northport VAMC for a total of 98." Aside from the victims treated, the VA immediately deployed assistive personnel to New York City, Pennsylvania and Virginia.

In communicating with VFW Service Officers and members located near the affected areas, we are proud to report that we have not received one complaint about VA's ability to complete its primary mission to serve veterans. Again, the VA is to be commended for carrying an increased workload while maintaining a continuity of services to veterans.

The VFW believes that VA's authority to respond to Department of Defense (DOD) contingencies is well documented in PL 97–174, the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act. This Act, codified in Title 38 U. S. C. § 8111A, and commonly referred to as VA's "fourth mission" states that VA will be the principal backup to DOD by furnishing health care services to active duty members of the Armed Forces in the event of war or national emergency "that involves the use of Armed Forces in armed conflict."

Further, Title 38 U. S. C. § 8110, dealing with the operation of VA medical facilities mandates the Secretary to "maintain a contingency capacity to assist the Department of Defense in time of war or national emergency."

VA's role to backup the military is clear. As the recent terrorist attacks have proven, however, national emergencies involve civilian casualties as well. Without doubt, PL 97–174, passed May 4, 1982, was based on the Cold War expectations that we would suffer mass military casualties conducting a land campaign in Eastern Europe and/or on the Korean Peninsula. Additionally, our national security strategy at that time was based on nuclear weapons and the concept of Mutually Assured Destruction (MAD).

As this committee considers how VA can best carry out its mission in the future, we feel it is important to take into account how national security has changed since the collapse of the Soviet Union and the proliferation of Weapons of Mass Destruction (WMD), specifically nuclear, biological and chemical. Recent reports, such as the U. S. Commission on National Security for the 21st Century (Hart-Rudman Commission), have all recognized that the "U. S. will become increasingly vulnerable to hostile attack on the American homeland" as well as be called upon to provide frequent military intervention abroad. It is no longer if the terrorists strike, but when.

So the question arises, how does VA fit into this new environment? One new strategy proposed for national security is homeland protection based on prevention, protection, and response. Common sense dictates that the VA, as the nation's largest health care network, will provide support under the response category. In fact, they already do.

We believe it was VA's role as a federal-level partner with the Federal Emergency Management Agency (FEMA) and the National Disaster Medical System (NDMS) that allowed it to respond to the civilian casualties so efficiently and effectively in the hours and days following the attack.

As one of 28 signatories to the Federal Response Plan (FRP) managed by FEMA, VA already has in place an inter-agency understanding that they will act as a support agency on 4 of 12 Emergency Support Functions (ESF) that FEMA uses to coordinate federal efforts to counteract the consequences of a national disaster. For example, VA's authority to treat the 98 victims it received in its New York Medical Centers was based on its support role in ESF #8, Health and Medical Services. Aside from Health and Medical Services, VA has a support role in ESF #3, Public Works and Engineering, ESF #6, Mass Care, and ESF #7, Resource Support.

VA's participation with FRP is more or less a defacto fifth mission and the VFW feels that it provides the most logical paradigm for VA's future response strategies and tactics in time of national emergency.

It is essential to point out that we are not advocating additional VA capacity for civilians. We, however, are mindful that DOD has been downsizing its medical facilities' beds for years and recent testimony before the Senate Appropriations Subcommittee on Labor, HHS and Education on the threat of biological terrorism has only highlighted the fragile state of the nation's public health system's ability to deal with multiple simultaneous disasters from WMD. The Senate testimony articulated that "financial problems have also transformed the health care industry in recent years, sharply reducing the number of available hospital beds and the size of the nursing staff and largely eliminating 'surge' capacity, or the ability to treat a sudden influx of patients resulting from a major disaster."

The same problems that threaten the public health system are the same ones that have been emphasized in past testimony to this committee regarding the VA health care system. Everyone is aware that the VA has been steadily transforming its health care system from inpatient to outpatient care for nearly a decade and the nursing shortage problem is nationwide. In addition, years of flatline budgeting have seriously eroded VA's ability to provide care to its primary constituency, the

veteran. The lack of a "surge" capacity in the public health arena only underscores the need for one at the federal level.

There is no other federal hospital system, other than VA, that can be expected to handle the overflow of patients from the public, private and DOD health systems resulting from a national emergency or act of war. Given the aforementioned testimony the potential for military and civilian casualties flooding the VA system and disrupting service to veterans is real. For example, what if there had been 6,000 wounded survivors instead of 6,000 fatalities as a result of the terrorist's actions in New York City?

Therefore, the VFW firmly believes that VA's goals during a national emergency should be twofold. First, VA must work to maintain services to veterans, as they aptly demonstrated they could do in New York and Virginia, while providing backup to DOD and FEMA. Second, given a scenario where they are overwhelmed in their support roles of handling civilian and military casualties, and the situation dictates that traditional veteran services must be reduced or even suspended, they must work diligently to return civilians to the public and private health care providers, where possible, to ensure room for DOD personnel as well as for veterans whose services were interrupted.

In order for VA to successfully respond to DOD contingencies and national emergencies, they must be properly prepared. Continued participation in local, state, and federal disaster training and the implementation of the FRP is the key to that preparedness. In addition, Congress, when using the power of the purse, must be mindful of VA's missions during acts of war and national emergencies. How can the VA be expected to carry out these support missions when it is struggling to carry out its primary mission of caring for the veteran?

We are hopeful that this discussion will assist in producing sound policy. Again, we are thankful for the chance to participate. This concludes my testimony and I would be happy to answer any questions you or the members of this committee may have.

PREPARED STATEMENT OF JACQUELINE GARRICK, CSW, ACSW, CTS, DEPUTY DIRECTOR, HEALTH CARE, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee.

Thank you for the invitation to contribute The American Legion's observations and recommendations to this extremely important hearing. On September 11, many American Legion members were sitting in the Committee's hearing rooms awaiting the National Commander's testimony before a Joint Session of the Veterans' Affairs Committees. As the horrendous acts began to unfold, Americans stood in disbelief. Fortunately, many Federal agencies are prepared to address such disasters with aggressive, coordinated activities.

As a clinical social worker and Certified Trauma Specialist (CTS), I volunteered to provide counseling support at the Pentagon Family Assistance Center in the Sheraton Hotel in Crystal City, VA. The American Legion graciously allowed me to spend many working hours assisting at the Center. I worked with both the Department of Defense's (DoD) Behavioral Mental Health Team and a nonprofit group, the Tragedy Assistance Program for Survivors (TAPS). Together, these two programs provide much needed support services at the Center or in the Pentagon. The American Legion provided resource materials and made referrals for financial assistance and peer support. Additionally, The American Legion Auxiliary donated $10,000 to provide children's grief workbooks and other self-help materials for the survivors and their family members.

The American Legion also re-instituted its Family Support Network to assist Reservists and members of the National Guard federalized to respond to this national emergency. During the Persian Gulf War, the Family Support Network provided much needed assistance to family members in local communities across the country. Services included such activities as childcare assistance, automobile maintenance, home repairs, and financial assistance provided by local members of The American Legion family. Over a half million dollars in grants were provided to the families of activated servicemembers during the Persian Gulf War. The American Legion renews this commitment to assist the citizen soldiers, sailors, airmen, Marines, and their families for the duration of this crisis.

Through this first-hand involvement, I witnessed the role of the Department of Veterans Affairs (VA) in responding to this tragic event. The Veterans Benefits Administration, Veterans Health Administration and the National Cemetery Administration were mobilized to assist in answering questions, providing mental health

services, filing for benefits, and assisting with burial arrangements. VA also worked with Federal Emergency Management Agency (FEMA), the Office of Crime Victims (OCV), American Airlines and the American Red Cross.

VA's National Center for Post-Traumatic Stress Disorder (PTSD) sent six team members from the Palo Alto Education Division to the Pentagon Family Assistance Center within days of the attack. After consulting with previous DoD contacts and obtaining permission from VA, the Division Director decided to drive, virtually non-stop across country, to respond to the disaster. For more than two weeks, this team provided psychological support and education to the recovery workers and family members at two separate locations.

At the Pentagon Family Assistance Center, VA's team provided:

- Psycho-education for counselors in support of families of missing or deceased.
- Debriefing of support staff, counselors, and other agencies (including Red Cross, FEMA, and DoD).
- Psycho-education and debriefing to Casualty Assistance Officers (CAO), who are charged with providing case management to the families of the deceased.
- Educational materials regarding disaster response for victims and helpers.
- Facilitator's guide for behavioral and emotional support debriefing for use by DoD counselors.
- Consultation with operation and mental health leadership in a long-term disaster response plan.
- Family support.
- Program evaluation questionnaire for CAOs to assess preparedness, effectiveness, and utilization of resources while providing services for family members of deceased victims.

At the US Army Community and Family Support Center Command Group in Alexandria, Virginia, VA's team provided:

- Psycho-education regarding human response to disaster and utilization of psychological first aid.
- Psycho-educational materials.
- Counseling to Pentagon employees.
- A survey for staff to use as self-assessment in response to the disaster.

The reputation and consultation services of the National Center are recognized throughout the world. The National Center provides more than simply long-term care for combat veterans suffering from PTSD, but also includes Acute Stress Disorder and Disaster Mental Health. This group published a guidebook that serves as the model for Pentagon relief efforts. The National Center for PTSD's recent performance demonstrates the valuable role of VA in response to such disaster. The presence of the National Center for PTSD was greatly appreciated by representatives of DoD, FEMA, Red Cross, OCV, TAPS, and the other responding organizations.

Initially, DoD did not plan to include VA in the recovery efforts. The plan used in responding to this disaster was from the National Transportation Safety Board (NTSB) model, which does not include VA. The American Legion strongly recommends that VA be added to NTSB's list. Under the Aviation Disaster Family Assistance Act of 1996, the Chairman of the NTSB may request the assistance of—

- American Red Cross
- Department of State
- Department of Health and Human Services
- Department of Justice and the Federal Bureau of Investigation
- Federal Emergency Management Agency
- Department of Defense

The National Center for PTSD has an ongoing agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA) to respond to disasters. In New York, the National Center coordinated efforts with Federal, state, and city officials. They continue to work with the New York Fire Department in planning the next phase of mental health services to be offered.

The National Center for PTSD provides resource materials on the immediate affects of trauma on survivors, families, rescue workers, and children through their website. As of last week, this website received approximately 50,000 lilts daily. The National Center expects to continue to play a major role in providing consultation, education, and research information in this post-disaster response.

There seems to be a need for an internal VA response and coordination protocol in the event of a national emergency. The American Legion recommends that the National Center for PTSD serve as the lead agent in coordinating such a protocol. Since there are 206 Vet Centers around the country that can be activated to provide counseling in local communities, the Readjustment Counseling Services is another valuable resource in helping to provide disaster relief.

The VA/DoD Health Resources Sharing and Emergency Operations Act of 1982 gives VA the mission as primary backup for DoD and FEMA in the event of a disaster or armed conflict. The National Disaster Medical System Federal Coordinating Center Guide identifies plans and coordination protocols for local exercises and responsibilities that include VA. However, according to the key assumptions in the VA Strategic Plan 2001–2006, "The United States will not engage in any major global or regional conflict during the period of this plan." Yet, the same plan lists as an objective, "Improve nation's response in the event of a national emergency or natural disaster by providing timely and effective contingency medical support and other services."

The American Legion remains concerned over this assumption. Currently, VA lacks the resources to fully staff the additional inpatient beds, if needed. VA must carry out a Continuity of Operation plan that includes annual tests, training, and exercises; preparation of alternate operating facilities; and identification of designated emergency planners. The American Legion believes the number of VA and DoD sharing agreements will increase over the next few years.

The American Legion recommends that VA should prepare a report on its emergency preparedness plans to treat mass casualties resulting from a national emergency.

In conclusion, The American Legion is truly touched by the outpouring of national support for the victims and their families. As a nation, Americans have come together to use their sense of humanity to best counter terrorism. Federal and organizational bureaucracies, that often seemed territorial and to act in isolation, overcame those barriers to provide much needed comfort and services to victims and families.

The National Center for PTSD will be issuing a more detailed report on its involvement in the response to this tragic event. The results of this report should help establish the framework for future national emergency contingency plans. VA must certainly be listed as a Federal agency that responds with NTSB. There should be on going communication and liaison activities between VA, DoD and FEMA in accordance with VA's mission to act as a backup to these Federal agencies. The American Legion requests that a new assessment and re-evaluation of VA's strategic plan be completed to determine if it has not underestimated the potential need for bed space and emergency medical care.

Mr. Chairman, that concludes this statement.

Chairman ROCKEFELLER. The hearing is adjourned.

[Whereupon, at 4:14 p.m., the committee was adjourned.]